

Networks at the Nexus: Revisiting New York State's Provider Network Standards and Protections

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Executive Summary

Hundreds of thousands of New Yorkers joined the ranks of the insured as a result of the Affordable Care Act. The confluence of this enrollment growth with other market trends and delivery system reform initiatives has made New York's provider network adequacy standards—minimum thresholds for the numbers and types of providers a network must contain—a top-of-the-mind issue for consumers, health plans, and policymakers. Several recent reforms and improvements undertaken by the State build on an already strong foundation. We revisited New York's network standards and consumer protections for this issue brief and convened a roundtable discussion with a range of interested parties.

In the current uncertain environment, a wholesale change to network adequacy standards would be difficult. Based on feedback from the roundtable discussion, the right path forward might be a more measured approach that includes steps to refine or supplement existing access standards, and to strengthen consumer protections and disclosure, including the following:

- Expanding current Medicaid Managed Care standards on **minimum waiting times** for appointments to enrollees in commercial markets;
- Creating a central database that health plans and regulators can use to adjust network information to reflect deaths, retirements, and changes in practice among providers, in order to improve the **accuracy of provider directories**;
- Improving access to New York's **appeals process** for accessing out-of-network providers;
- Enhancing **disclosure** so consumers know when a provider participates in a plan but does not accept new patients, or when a health plan has gaps in its network for which out-of-network access is permitted;
- Updating 20-year old standards that give consumers being treated for serious illnesses **continued access to important providers** when networks change;
- Supplementing new "**provider look-up**" tools for consumers with data that allow them to better compare their options; and
- Regularly **convening** providers, consumers, health plans, and policymakers to help address issues with New York's standards, including the shortages of providers in rural areas.

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Introduction

With hundreds of thousands more New Yorkers joining public and private insurance markets since the enactment of the Affordable Care Act (ACA),^{1,2} and health plans seeking to control costs through narrower networks of providers, network adequacy standards and consumer protections have come to the fore. In a national survey released just before the November 2016 elections, Americans cited “making sure health plans have sufficient provider networks of doctors and hospitals” as their second-highest health care priority for the next President and Congress, ranking only behind the affordability of prescription drugs.³ At the same time, State and federal policy initiatives are driving improvements in the primary care component of networks,⁴ and encouraging health plans to shift risk to provider groups and systems in value-based payment arrangements.⁵ All of these developments have placed networks at the nexus of important policy and health system goals, such as reducing costs, improving quality and patient experience, and reinforcing the value of coverage that is fundamental to consumers’ decisions to purchase a plan.

Building on a sound network regulation structure already in place before the enactment of the ACA,⁶ New York adopted sweeping legislation in 2014⁷ that

brought all provider networks under State review and created new network-related consumer protections. Currently, New York is fine-tuning an ambitious rebuild of the Provider Network Data System (PNDS), the cornerstone of network regulation. This issue brief, a follow-up to an earlier work,⁸ revisits New York’s network adequacy standards and consumer protections in light of these changes. As part of our research, we interviewed health plan officials, consumer groups, providers, and state regulators; obtained and analyzed health plan network filings; reviewed New York State laws and regulations; and surveyed network-related activities on the federal level and in other states. We capped our research with a December 2016 roundtable discussion (the Networks Roundtable, see inset box) that brought a diverse group of interested parties together to discuss current issues and potential approaches to improve network regulation in New York. The discussion was organized in four areas—the impact of the new PNDS, New York’s

The UHF Networks Roundtable

UHF’s Networks Roundtable brought together providers, consumers, health plans, lawmakers and New York State officials for a discussion of New York’s network adequacy standards and consumer protections. The day featured presentations from:

- New York State Department of Health Research Scientist Kate Bliss, who provided an overview of new PNDS improvements and tools;
- Oscar Insurance Corporation CEO Mario Schlosser, who discussed his company’s implementation of a smaller network for 2017, and the way it utilizes virtual care and high-touch service to aid members in finding and receiving care;
- Mark Scherzer, Esq., legislative counsel for New Yorkers for Accessible Health Coverage, who offered the consumer perspective; and
- UHF Health Insurance Project Director Peter Newell.

Slide decks from the presentations are available at www.uhfnyc.org/publications/881210

basic network adequacy standard, consumer protections, and disclosure rules. Several themes emerged in the discussion, including the complexity of organizing and regulating provider networks, competing goals, and how best to thread the needle in an environment characterized by the uncertain direction of federal health policy. But the outline of a path forward emerged as well, and included harnessing the capabilities of the new PNDS, updating and fine-tuning existing consumer protections, providing more useful information to consumers, and adopting some common-sense approaches to improving the accuracy of network information. This issue brief follows the same framework as the discussion of the Roundtable; we begin with some background information to provide context for this discussion.

Background

Consumer concerns on networks may reflect health plans' increasing use of smaller networks to control costs, a strategy that began long before the adoption of the ACA⁹ but has taken hold in Exchange markets.¹⁰ According to a 2015 study, New York ranked in the middle of the pack among states, with 20 to 40 percent of 2014 marketplace networks categorized as "narrow."¹¹ Before 2014, all HMOs were required to offer out-of-network benefits to individuals, though the products were very costly. But now, individual products with out-of-network benefits are only available in limited parts of the state. The trend toward narrower networks provides the biggest challenge to network adequacy reviews, and it is directly tied to the value consumers perceive in purchasing health coverage, given its cost.

Three State agencies share duties for network adequacy determinations, applying a mix of state and federal standards through statutory authority, procurement guidelines, and contractual provisions: the Department of Health (DOH), New York State of Health (NYSOH, the state's ACA Marketplace or Exchange, embedded within DOH), and the Department of Financial Services (DFS).¹² Over a dozen programs are subject to state oversight, mapped out in Table 1, including public programs like Medicaid Managed Care (MMC), as well as commercial products offered on and off the Exchange to individuals and groups. While there are slight differences in requirements among the programs New York monitors, the process the agencies use is highly aligned. The PNDS sets out requirements for over 130 core providers and services, health plans submit their networks electronically, and regulators then determine if the submission satisfies requirements for "access" (one provider per county) and "choice" (two or more providers per county) in most of the required categories, with slightly higher requirements for hospitals and primary care providers.¹³ For the most part, New York's access/choice standard is a relatively low bar that health plans routinely exceed for competitive reasons or a sense of their mission. The standard does come into play, however, in rural areas, where there

Table 1. New York State Network Adequacy Reviews by Program and Agency

Programs	DOH	NYSOH	DFS
Medicaid Managed Care	✓		
Child Health Plus	✓		
Managed Long-Term Care	✓		
Medicaid Advantage/Plus	✓		
Fully Integrated Duals Advantage (FIDA)	✓		
Health and Recovery Plans	✓		
HIV Special Needs	✓		
Program of All-Inclusive Care for the Elderly (PACE)	✓		
Off-Exchange Commercial (HMO)	✓		
Qualified Health Plans (QHP)		✓	
Essential Plan (also known as Basic Health Plan, BHP)		✓	
Off-Exchange Commercial (Non-HMO)			✓
Stand-Alone Dental Plans			✓
Stand-Alone Vision Plans			✓

Source: New York State Department of Health, PNDS Data Dictionary, Version 7.6.

might be a shortage of providers—or at the edge of a plan’s service area, where its smaller market share can affect providers’ willingness to participate in the network. When gaps or deficiencies in the network are identified, regulators and health plans enter into agreements that require the plans to make that service available to enrollees on an out-of-network basis at no additional cost beyond regular cost-sharing for in-network providers.¹⁴ In addition to these regulatory reviews, statutory provisions also provide a safety valve for access to out-of-network providers when the network lacks providers who can meet an enrollee’s needs.¹⁵

Table 2 illustrates some of the network requirements that flesh out the access/choice standard in New York and, for comparison purposes, related federal standards. Programs are listed across the top, and include MMC; Child Health Plus (CHP); NYSOH (Qualified Health Plans or QHPs for individuals and small groups, and the Essential Plan for lower-income individuals); network-based commercial products sold off the Exchange in the individual, small and large group markets; the Federally Facilitated Marketplaces (FFM) in states which did not set up their own ACA exchanges;¹⁶ and Medicare Advantage (MA). The column on the left shows the different network adequacy review variables used for these programs, such as the geographic area, time and distance standards, maximum waiting times for appointments, minimum provider-to-enrollee ratios, and the relative size of a health plan’s network (“network breadth”).

In addition to the network reviews, New York has enacted a number of consumer protections to backstop network adequacy determinations. The 1996 Managed Care Reform Act (MCRA)¹⁷ added disclosure and continuity-of-care provisions, and rights for consumers to appeal health plan determinations to independent review agents. These protections were significantly enhanced with the Surprise Bills law of 2014,¹⁸ spurred by a 2012 Department of Financial Services investigation,¹⁹ which has become a national model.²⁰ The law includes hold-harmless provisions for consumers who unwittingly accessed out-of-network services and incurred large expenses, a dispute resolution system for health plans and providers to resolve out-of-network billing problems, and new rights for enrollees to appeal health plan denials of access to out-of-network services or providers.

Table 2. Comparing State and Federal Network Adequacy Standards

	MMC/CHP	NYSOH	Commercial	FFM	MA
Area	County	County	County	Urban/Rural	Urban/Rural
Time/Distance	Yes	Primary care	Primary Care	10 provider types	Yes
Timely Access	Yes	No	No	No	No
Ratios	Primary care	Primary care	Primary care	No	35 provider types
Network Breadth	No	No	No	Pilot program	No

Source: New York State Department of Health. Data Dictionary. Provider Network Data System (PNDS) Version 7.6 (March 2017); Medicaid Managed Care/FHP/HIV Special Needs Plan Model Contract, March 2014. New York State Department of Health, https://www.health.ny.gov/health_care/managed_care/docs/mcicaid_managed_care_fhp_hiv-snp_model_contract.pdf; Contract Year 2017 Medicare Advantage Health Service Delivery Provider and Facility Specialties and Network Adequacy Criteria Guidance and Methodology, https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2017_MA_HSD_Network_Criteria_Guidance.PDF, see HSD Reference File; and Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, 2018 Letter to Issuers in the Federally-facilitated Marketplaces, December 16, 2016; HHS Notice of Benefits and Payment Parameters for 2018; Final Rule, CMS 9934-F, published on December 16, 2016.

Revisiting New York’s Provider Network Standards and Consumer Protections

The New PNDS

New York’s information system for network adequacy dates back to 1996, built in response to new federal guidelines for mandatory MMC networks. When a senior state official at the time noted with alarm the over 10,000 floppy disks containing health plan provider networks piling up on a conference room table, the old PNDS was born, allowing electronic submissions in a uniform data format, and more structured interactions between plans and regulators.²¹

After a two-year collaboration among multiple State agencies and four vendors, New York officials are gradually rolling out a major upgrade of the PNDS.²² Based on several demonstrations,²³ the new PNDS is a huge improvement, with the capacity to handle the increased workload of network reviews created by the Exchange, placing non-HMO commercial products under review, and expanding managed care to more public program enrollees. In addition to reducing network reviews from weeks to just days, and bringing new and sophisticated tools to DOH, NYSOH, and especially DFS (which has been processing network reviews manually), the new PNDS should also remediate two big problems consumers face: inaccurate provider directories, and the lack of tools to shop and compare plans based on in-network providers.

Inaccurate provider directories have been a persistent and lingering problem across product lines and across the country²⁴—and a major source of frustration and financial exposure for consumers. The rebuilt PNDS will support updates throughout the year, rather than annually or quarterly, and includes an upfront standardization and data validation component that will help clean up nettlesome variations in addresses and names, and problems associated with providers working at multiple addresses. Direct, online communication between plans and regulators will replace emailed spreadsheets, and providers will have the ability to check their own listing of participation across plans and products, and to directly notify regulators of errors; consumers will be able to do the same.

Some additional attention to data available to the new PNDS and health plans could further improve accuracy. Participants at the Networks Roundtable cited recurring problems caused by providers who died, retired, moved, or changed their practices. These problems may be related to the two-year reregistration cycle used by the State Education Department (SED) for medical licensees, and to the fact that providers or group practices are not required to notify the agencies or plans of changes which affect network participation status.²⁵ Under current SED rules, the license of a provider who retires or moves to another state might just be placed in an “inactive” list if the provider fails to renew his or her license. One

speaker praised the State's Office of Professional Medical Conduct (OPMC), which issues automated notifications to a broad list of health plans, State agencies and facilities when disciplinary actions are taken against a licensee, since it might affect their participation with a health plan, or affiliation with a hospital or other facility.²⁶ OPMC data is also used in the PNDS validation process, and health plans are alerted when a provider has been excluded. Another participant suggested requirements for health plans to contact providers to investigate their status when no claims have been submitted for a given time period, as is required in New Jersey.²⁷ California's network accuracy regulations allow health plans to delay reimbursement for network providers which do not respond to requests for information.²⁸ One possible improvement in this area would be requiring providers and medical groups to report changes due to deaths, retirements, moves, or practice changes to a central database, and make it available to health plans. This would impose a new obligation on providers, but reduce the administrative burden on providers contracting with multiple health plans or for different products.

In addition to improved accuracy, the new PNDS will also support a provider look-up tool across all markets and programs, known as the NYS Provider & Health Plan Look-up. Although MMC enrollees and NYSOH account holders have access to a "doc-find" tool to check providers participating with plans, the new PNDS master database of providers will support a tool that will allow both shoppers and enrollees in all insured markets to compare provider networks in plans generally, or for a particular specialty, and to identify all the plans and products in which a consumer's valued providers participate. While not quite as intuitive or robust as the Oscar look-up tool highlighted at the Networks Roundtable—which included mapping functions, data about the age and sex of a provider's patients, a search function tied to symptoms, comparative provider cost information, and the ability to schedule appointments—the new PNDS tool is a big step forward.

Given the many programs subject to review, and the large number of separate products within some programs, the biggest challenge will be displaying the network information in a way that makes it easy for consumers to match it to the program they are interested in, or the health plan and product in which they are enrolled. State regulators have worked hard to standardize products on the Exchange and establish naming conventions to make it easier to sort through product variations,²⁹ and the new PNDS has a protocol for plans to submit multiple products with different networks in a single filing. Websites maintained by health plans such as Independent Health Association and Capital District Physicians' Health Plan help enrollees connect with the correct look-up tool by plugging in their ID number or showing where on their insurance ID card to find the name of the product in which they are enrolled.³⁰

New York’s Network Adequacy Standards

While the new PNDS represents a big and positive change in the 20-year old system for network reviews, New York’s basic standard has not changed much at all, except for new products subject to review, and required services. The most obvious potential enhancements to current “access/choice” standards are those described in Table 2. Federal Medicare Advantage standards set minimum provider-to-enrollee ratios for over 35 provider types and about 30 different kinds of facilities. Guidance for participating MA plans,³¹ for example, requires a minimum of 13 primary care providers and two cardiologists for Albany County, and 42 primary care providers and 7 cardiologists for Brooklyn, further adjusted based on the plan’s market share and MA enrollment overall.³² Two states, California and Washington, have adopted timely access and time and distance standards for commercial plans.³³ Oregon allows health plans to choose a national network adequacy standard, such as Medicare Advantage, or a “factor-based” methodology, which includes compliance, transparency, consumer satisfaction and quality.³⁴

Under New York standards, which are currently under review,³⁵ provider-to-enrollee ratios apply only to primary care providers and certain dental services. A second option to consider would expand “timely access” provisions that apply to MMC, more broadly to commercial and NYSOH plans. MMC contracts, for example, require plans to provide non-urgent “sick” visits within 48 to 72 hours; routine, preventive appointments within four weeks; and non-urgent, specialty appointments within four to six weeks.³⁶ A third option would expand time and distance requirements more broadly to commercial plans; currently, commercial and NYSOH plans are subject to these standards for primary care providers, but not for other services.³⁷ Since the New PNDS includes a geocoding component to more accurately compute time and distance, which is already used in identifying gaps in networks, this option would be well within the capabilities of the new system. The timely access standards perhaps most directly address consumers’ concerns that narrower networks will lead to longer waits to see providers. It would also help address a major shortcoming of network reviews. Health plan networks are evaluated independently, even though a participating provider might also participate with other health plans in the same region. A timely access standard would help ensure that enrollees receive timely appointments from providers who participate in multiple networks. For the MMC program, primary care providers with large numbers of enrollees through contracts with multiple plans are tested against timely access standards.

One final area raised at the Networks Roundtable was access to cancer care. Representatives of Memorial Sloan Kettering Cancer Center (MSKCC) described how they participate in all networks for all self-funded and fully-insured group plans, but have been virtually shut out of the individual public and private markets as participating providers—though they have “single case” agreements in place with plans to treat certain patients on referral. Despite the ACA’s risk adjustment and

reinsurance program, designed to shield health plans from the premium impact of covering a disproportionate share of costly patients, MSKCC officials believe that health plans omit the cancer center from their networks to avoid cancer patients. Access to cancer care in Exchange products has been identified as a national problem.³⁸ A network standard requiring regulators to pick and choose which individual providers or facilities must be included in networks would be operationally difficult and very hard to apply fairly. But in the case of cancer care, the independent National Cancer Institute awards designations to cutting-edge cancer centers. MSKCC is one of three New York facilities with the highest designation—“comprehensive cancer center”—out of 45 in the nation; and two other facilities in New York are designated cancer centers.³⁹

A network standard incorporating this type of independent imprimatur would help ensure that individual and public program market enrollees facing serious illnesses have the same access as group plan enrollees, and, at the same time, that no single plan would attract a higher proportion of individuals needing such care, since all health plans would be in the same boat. Another approach would be to sharpen the current ambiguous statutory language⁴⁰ requiring health plans to establish procedures for enrollees with “life-threatening, degenerative or disabling conditions” that may require “specialized medical care over a prolonged period of time” to access specialty care centers with expertise in the area. Health plans maintain lists of such specialty care centers, which are reviewed by State regulators as part of regular certification audits. The specialty care lists are submitted to regulators in a “supplementary file,” but they are typically not included as part of the automated PNDS review or network adequacy determinations. Although specialty care centers are not part of PNDS network adequacy reviews, NYSOH reserves the right to consider them as part of its overall network review, through its procurement process.⁴¹

Consumer Protections

Almost three years after its passage, New York’s Surprise Bills law still has the scent of a hard-fought, lengthy, negotiation with plenty of give-and-take by a diverse set of stakeholders. Legislation like this is sometimes hard to “reopen,” but there are a couple of areas that deserve a second look. While the law generally receives high marks from all quarters, and the dispute resolution process it created seems to be working as planned, questions have arisen about the standards under which consumers gain the hold-harmless protections for unwitting use of out-of-network services, as well as the new appeal rights to seek care out of network when in-network providers lack the experience and training.

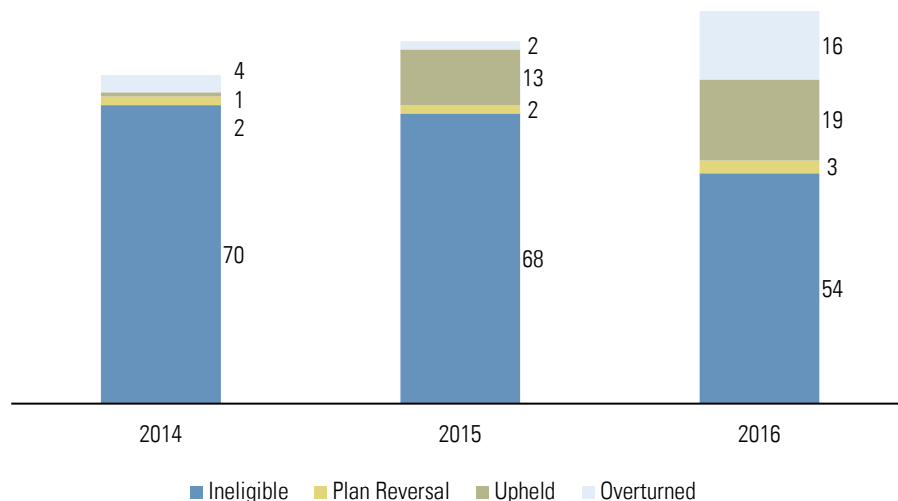
Addressing the problems of some groups left out of the Surprise Bills law’s financial protections will not be easy. Enrollees in self-funded employer groups are not fully included, due to limitations on state regulatory powers under the federal Employee Retirement Income Security Act (ERISA), nor are those covered under out-of-state,

fully insured, employer-sponsored plans covering New York residents. One recent research paper on the problem called for a federal solution.⁴² On the other hand, the New York Attorney General settlement on provider directory accuracy did include companies which recruit and organize networks of providers and lease them to self-funded employer health plans for a fee,⁴³ and New York has some regulatory leverage with New York-headquartered, licensed insurers acting as administrators for self-funded arrangements.⁴⁴ With interest high among states in solving the surprise bill problem, reciprocal agreements that bring out-of-state, fully insured plans into the fold may be possible.

More amenable to remediation may be the situations that leave consumers outside the law's protections, such as limited cases in which individuals are enrolled in Participating Provider Organizations or Exclusive Provider Organizations that do not require referrals for specialty care⁴⁵—as referrals, along with emergency care, are an important trigger of protections under the Surprise Bills law. In such cases consumers may make good-faith decisions on selecting providers but be misinformed either by health plan personnel or provider directories, or by providers themselves, who also have some disclosure obligations under the Surprise Bills law.⁴⁶ For some of these cases, the new PNDS will be useful in providing a “point in time” record of the information available to consumers when they made choices, since it will be continuously updated. When complaints arise, NYSOH requires health plans to abide by the provider network data that is shown to consumers during the enrollment process. Developing a record of network information relayed over the phone by providers is harder, but a similar hold-harmless approach would be helpful to consumers when they rely on provider-supplied plan participation information.

The expansion of the right to appeal a health plan's denial of a request for out-of-network services or providers was a major component of the Surprise Bills law. Data on appeals under the law between 2014 and 2016 show mixed results (Figure 1). About three-quarters of appeals to date have been found to be ineligible for consideration, although the percentage of ineligible appeals dropped from 91 percent in the first partial year of operation, to 60 percent in 2016. Although outside reviewers found in favor of consumers only 22 times thus far out of over 250 appeals since 2014, 15 of those decisions came in 2016, and health plans reversed their earlier denials an additional 7 times.⁴⁷ These results could mean that consumers are finding the right providers within networks, or that plans are granting out-of-network access without appeals or through an internal grievance process. The high rate of ineligible filings, however, suggests that, at the very least, consumers and providers do not understand how the law works, or that the bar is set too high. At the Networks Roundtable, a speaker commented that attending physicians for the appealing enrollees might be reluctant to certify that the available in-network providers (which could include professional colleagues) weren't up to the job of treating a patient, suggesting the need to revise the role of the attending physician in the application process. The speaker also called for the publication of redacted

Figure I. Disposition of Network-Related External Appeals by Consumers, 2014 to 2017



Source: UHF analysis of data on external appeals for out of network services and providers, obtained through personal communication with the New York State Department of Financial Services

Note: “Overturned” means an independent review agent decided in favor of a consumer’s appeal, and “upheld” means the reviewer upheld the plan’s original denial of out-of-network access. Data for 2014 reflect the second half of the year only.

appeals decisions as a learning tool for consumers and their advocates. Since it is an important network adequacy safeguard, more study of the results of the program thus far would be worthwhile.

Another consumer protection worth revisiting is the set of Managed Care Reform Act (MCRA) special transition rules,⁴⁸ which allow enrollees whose provider was terminated without cause to continue seeing that provider for up to 90 days, and allows new enrollees who are facing a life-threatening condition or a degenerative and disabling disease to continue treatment with their provider for up to 60 days, even if that provider is not in their new plan’s network. In both instances, these transition periods only apply if the provider in question abides by the health plan’s procedures and accepts the plan’s normal reimbursement. Disruption in the individual market in New York because of the Health Republic insolvency, and the limited number of health plans that have withdrawn, suggest that reviewing these continuity standards is also in order—in terms of both the length of the transition, which may not provide enough time to complete a course of treatment, and the conditions that trigger the transition. Minnesota recently enacted legislation⁴⁹ enlarging the list of conditions that trigger out-of-network utilization, and increasing the time period to 120 days, or indefinitely for terminally ill patients, in cases where a plan leaves the market. Like New York’s law, providers must accept the health

plans' reimbursement rate, but Minnesota also created a fund to offset additional health plan costs for the transition.⁵⁰ Similarly, a California statute adopted in 2014⁵¹ provides for the “completion of services” for enrollees by non-participating providers when networks change, for up to one year for enrollees with serious chronic conditions.

One final important consumer protection worth revisiting is a fundamental one, the ability of enrollees to access out-of-network care at no additional cost when networks lack needed providers. It may be time to update and clarify underlying statutes and regulations in light of new benefit designs and current regulatory standards. Longstanding provisions for HMOs,⁵² included more recently in insurance law provisions for non-HMO networks,⁵³ provide that when a plan “determines that it does not have a health care provider with appropriate training and experience...to meet the needs of an enrollee, the [plan] shall make a referral to an appropriate provider, pursuant to a treatment plan approved by the [plan] in consultation with the primary care provider, the nonparticipating provider and the enrollee or enrollee’s designee, at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network.” The statutory requirements for a “referral” and a “treatment plan” approved by the plan in consultation with a primary care provider, though perhaps directed appropriately at care coordination, do not reflect some current benefit designs in which enrollees might not have a primary care provider, or need referrals to access specialists.

Disclosure

State policymakers could consider a number of options to improve network-related disclosure requirements, including some updates of MCRA standards, and some newer ideas. The MCRA, for example, requires general disclosure to enrollees on the types of payment methodologies used for providers,⁵⁴ but fulfilling that broad requirement may not provide all of the information a consumer could use if, for example, their network includes a health system compensated through a full-risk capitation agreement under which they must pay for all services, even when an enrollee receives care from a provider who participates in the larger health plan network but is not affiliated with the system taking on the risk. In these kinds of payment arrangements, risk-taking providers have strong incentive to limit access to providers within their system. A second potential area of improved transparency is disclosure of the gaps or deficiencies in a health plan network, contained in the letters of agreement between regulators and health plans, and a clear statement of the right of consumers to seek out-of-network care when needed providers are not available. The network deficiency agreements plans enter into with DOH and NYSOH simply provide that the “insurer will permit its members to access non-participating specialists and/or ancillary providers in the counties/provider types listed below until such time as an adequate network is established.”⁵⁵ DFS uses a

similar approach in its network reviews. Currently, the knowledge of network gaps is asymmetrical; health plans and regulators know the counties and services for which out-of-network services must be provided, but enrollees do not.⁵⁶

In the case of a plan such as HealthFirst, a provider-sponsored health plan operating in the downstate area, a 2016 evaluation by NYSOH found only two gaps in its network, so there would be limited use for the information. But for an upstate plan such as Excellus BlueCross BlueShield, or a statewide plan such as Fidelis—both of which operate in large service areas including many rural counties with more shortages of providers and fewer competing health plans—information on gaps might be more useful; agreements with these plans show many counties in their service areas with multiple required providers lacking, adding up to hundreds of gaps overall.⁵⁷ Disclosing all gaps to all enrollees makes no sense, but the new PNDS’s ability to maintain up-to-date information on networks, along with its communication features, might support consumer inquiries about network gaps. Current law includes provisions requiring health plans to provide information to enrollees upon request. Knowledge of specific gaps could possibly prompt consumers to shop for a different plan, if needed, or to raise the issue of a missing provider with a health plan early on, rather than after a service denial.

In addition to knowing about the gaps in a network, another possible area for additional disclosure would be the “panel status” of providers within a network—whether they are accepting new patients (open) or not (closed). The new PNDS now collects information from plans on their primary care providers’ panel size and status, but this information will not be included in the initial PNDS provider look-up tool, and it is not collected for specialty care. Including that information would be very useful to consumers who are choosing a plan or using their network. A speaker at the Networks Roundtable, for example, recounted how an employee recently needed to contact eight primary care providers listed in his member directory before he found one accepting new patients. Knowing the panel status of participating providers would also provide consumers with a better sense of a network’s true breadth; a network with, for example, eight endocrinologists, six of whom are accepting new patients, might be more desirable than a network with 10 endocrinologists, only two of whom are accepting new patients.

Including the disclosure of panel status would certainly be challenging, since it requires strong compliance by providers and frequent updating; in many cases, a provider might participate with a health plan in one program, such as commercial coverage, but not another, such as MMC. Should it be administratively too complex to include panel status for all providers and specialties, information could be included for a subset of key specialists, an approach taken in recent FFM guidance,⁵⁸ or the selection used in a recent analysis of access to specialty care.⁵⁹ Extra effort would be required by health plans to verify the status of their providers; Independent Health is an example of a health plan that delineates participating providers by panel status for enrollees using their online guide.⁶⁰

Disclosure of data that helps consumers compare plans was a major focus at the Networks Roundtable. One speaker suggested making available a “Barron’s College Guide” for health plans. Another concept gaining consumer support, known as “T-shirt size,” would categorize networks as small, medium, large or extra large based on the size of their networks compared to other health plans in the region and market. A FFM demonstration program in four states categorizes plans as “basic,” “standard,” or “broad,”⁶¹ with a fourth designation for “integrated delivery system” also under consideration. The FFM designations are county-based, and computed by comparing plans’ providers to all the providers participating with plans in the county, with a focus on adult primary care, pediatric care and hospitals. Some have argued that network breadth information may be of little use to consumers in areas where all networks are of similar breadth, but that might not be the case in all regions. And, based on a recent demonstration of the network adequacy component of the new PNDS, it may not be unduly burdensome to develop such a comparison tool in the future. For health plans with gaps, the system displays a list of providers not included in the filing for the network under review, but which participate in all other programs, for all other plans. In and of itself, a size comparison has its limitations. Many plans might be of similar size, a larger plan may not translate to better quality or shorter waiting times for appointments, and a smaller plan relying on high-value, integrated delivery system might be the best bargain. But consumers are clamoring for comparative information on networks, beyond whether a valued provider participates, so a simple system comparing network breadth would be a welcome addition.

Discussion

Many important and complex issues are intertwined in the discussion of network adequacy standards, including finding the right balance between affordable premiums and network composition, and the impact of narrower networks on quality and access for patients. There is considerable evidence that narrower networks can reduce costs.⁶² At the networks roundtable, Oscar CEO Mario Schlosser noted that the company’s reconfigured network did not include a health system in which less than 10 percent of members had contact, but that health system nevertheless accounted for \$16 per member per month in premiums. Consumers also respond to networks differently, as demonstrated in a study of purchases on the Massachusetts Health Connector that found older enrollees were willing to pay twice as much as younger enrollees for broader hospital networks.⁶³

The effect of narrow networks on quality has yet to be determined, but recent research in Massachusetts and California found no drop of in quality or access with narrower provider networks.⁶⁴ Extensive quality data is available on health plans in New York, but quality measurement plays a limited role in New York’s *network* adequacy standards. Providers with licensing or disciplinary problems are screened

out, but New York's Quality Assurance Review Reporting (QARR) system—though it rates health plans on dozens of performance measures—bases network quality on rates of board certification at the health plan level for four primary care specialties and consumer satisfaction.⁶⁵ NYSOH incorporated QARR measurements for networks in its earlier star rating system for QHPs, and now relies on the Centers for Medicare & Medicaid formula.⁶⁶ But the question remains whether a quality rating for a health plan is a good proxy for the quality of the network that the consumer will be using when they buy or enroll in one of many products offered by the plan, often through multiple licenses, or the availability of particular high quality specialty providers or facilities in the product they select. Participants at the Networks Roundtable noted the still evolving work on quality measurement, and the differences between the quality information consumers value—such as a provider who treats them with respect—compared to the clinical measures that are typically the focus. A transitional approach to network quality measurement might be to provide cues to consumers on the wealth of quality information available in New York⁶⁷ at propitious times—such as when they are choosing a health plan or a provider.

Whether New York decides to stick with its current network adequacy standard or revise it, ensuring compliance is an overriding concern. California regulators checking compliance with the state's timely access requirements recently announced that health plans' directories were so riddled with inaccuracies that the review was impossible.⁶⁸ Depending on the line of business, New York health plans are subject to statutory and contractual requirements for updating and monitoring networks, as well as accreditation requirements, for some plans, through entities like the National Commission for Quality Assurance. The settlement agreements entered into with plans by the New York Attorney General's Office on inaccurate provider directories included protocols for plans to follow in keeping network information up to date.⁶⁹ MMC Plans are subject to the most stringent standards, which include periodic audits by External Quality Review agents that test provider network directory accuracy and access by contacting providers directly, and the submission of corrective action plans when problems are found.⁷⁰ Although health plans chafe at "secret shopper" tests, arguing that providers many times simply (and repeatedly) give the wrong answer, it is generally accepted that direct testing is an effective tool. But even this approach has yielded mixed results for MMC plans,⁷¹ in terms of the accuracy of provider directories, and the wide range of compliance with timely access standards. Certainly, any discussions of network adequacy standards should include a discussion of well-aligned requirements and strategies to ensure compliance, along with the necessary support for the cost of monitoring it.

Conclusion

Summing up the free-flowing Networks Roundtable discussion, UHF President James R. Tallon noted the complexity of imposing a structure and organization on the network adequacy process, compounded by the uncertainty surrounding federal health policy. It is complex indeed. Statewide health plan Fidelis Care contracted with nearly 70,000 providers for its networks in 2015.⁷² From the other end of the telescope, New York-Presbyterian Hospital lists almost 50 different insurers and plan administrators it accepts, encompassing about 125 separate products for the hospital alone.⁷³ In certain group practices and independent practice associations, there are providers that participate in some but not all of a plan's offerings.

New York policy- and decision-makers face a range of design and policy questions for the New PNDS and network adequacy standards. As State officials fine-tune the new PNDS, design questions include whether county is the best unit of measurement, the utility of the provider look-up function for enrollees (as opposed to a shopping guide and compliance tool), and the option of changing to the federal taxonomy for provider categorization (as opposed to the traditional PNDS list).⁷⁴ The policy issues and trade-offs involved in network adequacy—supporting competitive markets in which consumers have a choice of plans; maintaining affordability but also reinforcing the value in having coverage through strong access; compliance; the role of quality in network evaluations; how to keep pace with changes in the delivery system and innovations like telemedicine; and the extent to which networks should reflect policy goals like advanced primary care—are no less complex than setting up networks in the first place. Decisions on future federal health policy could touch nearly every aspect of public and private markets in New York, particularly the affordability of coverage. But despite the challenges, there are some encouraging features in this landscape as well.

Based on recent federal regulations,⁷⁵ New York is likely to remain responsible for network adequacy determinations. Some problems, such as keeping track of deceased providers or those with practice changes that affect their participation, seem solvable. The new PNDS will improve network regulation immediately in many ways, such as allowing providers to check if their network affiliations are correct, and the new system appears to have the capacity to handle technical and policy changes in the future. The wide-ranging Networks Roundtable discussion suggested the outlines of a path forward through the current thicket of market forces, policy activity and federal uncertainty.

Health plans were most concerned with changes in standards that run counter to value-based payment directives, or that might blunt their efforts to restrain premium growth. Provider groups cited financial pressures, and a mountain of new system challenges related to electronic medical records, quality measurement, and practice

transformation. Consumer groups, although still interested in broader availability of out-of-network benefits, did not clamor for dramatically increased minimum provider ratios or the rejection of networks currently in use, but instead focused strongly on two areas: improving the amount and quality of information consumers have on hand to make decisions; and the need to fine-tune and strengthen existing consumer protections in order to keep enrollees out of harm's way when network adequacy "fails" occur. Overall, the Networks Roundtable discussion also suggested the value of a formal, annual review of network adequacy standards and consumer protections by all parties, an approach adopted by the state of Nevada.⁷⁶ Timed perhaps to coincide with annual procurements or network reviews, such a process could help New York stay a step ahead of an evolving health care landscape. And since no adequacy standard will conjure up needed providers where they simply don't exist, it could also serve as a forum for systematically tackling the shortages of providers in certain parts of the state.

Endnotes

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- 13 New York State Department of Health. PNDS Data Dictionary, V.7.5, December 2016, available at https://www.health.ny.gov/health_care/managed_care/docs/dictionary.pdf; and New York State Department of Health, Division of Managed Care, Bureau of Managed Care Certification and Surveillance Guidelines to Review MCO Service Delivery Network, obtained through personal communication with DOH. Differences include lower provider-to-enrollee ratios in MMC/CHP for primary care (1:1,500) than for commercial HMOs (1:2,500), and differences in required providers related to populations served by programs. For example, child psychiatrists are not required for Managed Long-Term Care networks.
- 14 UHF obtained “letters of agreement,” also known as “statements of agreement” between health plans and State regulators at the Department of Health and New York State of Health through Freedom of Information Law requests and personal communication with State agencies. Typically, these agreements

provide that “Insurer will permit its members to access non-participating specialists and/or ancillary providers in the counties/provider types listed below until such time as an adequate network is established. Enrollees accessing such non-participating specialists and/or ancillary providers will be responsible only for the respective in-network cost-share.” The Department of Financial Services uses a slightly different approach in which health plans agree at the beginning of the network adequacy review to provide out-of-network access when deficiencies are identified, and are then notified of the specific gaps for which out-of-network access applies.

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