January 12, 2015

Mr. J.P. Weiske  
Chair, Network Adequacy Model Review Subgroup  
Ms. Jolie Matthews  
Senior Counsel, Health and Life Policy  
National Association of Insurance Commissioners (NAIC)  
Network Adequacy Model Review Subgroup  
444 North Capitol Street NW, Suite 700  
Washington, DC 20001

Dear Mr. Weiske and Ms. Matthews:

The American Academy of Ophthalmology appreciates the opportunity to comment on the revisions to the Managed Care Network Adequacy Model Act of the National Association of Insurance Commissioners (NAIC) as posted on the NAIC website. The Academy is the world’s largest association of eye physicians and surgeons—Eye M.D.s—with 19,000 members in the United States. We are pleased to provide our input on this important document.

The Academy supports the goal of revising the Model Act to provide a means for states to better monitor and assess Qualified Health Plans (QHPs). With the suggested revisions, we believe that that NAIC will be putting for a model that will ensure that healthcare consumers will be able to receive quality care from the most appropriate providers.

Our comments focus on three areas:

- Section 5 – Network Adequacy;
- Section 6 – Requirements for Health Carriers and Participating Providers; and
- Section 8 – Provider Directories.

**Section 5 - Network Adequacy**

The Academy considers *Section 5 – Network Adequacy* a critical component of the Model Act. It is in this section that the term network adequacy is defined, criteria to assess network adequacy are listed, guidance on how a plan will address coverage issues when an in-network provider is not available for a covered benefit, and access plans are discussed in great detail.

**Definition – Network Adequacy**

In section 5A the following definition of network adequacy is provided:

*A health carrier providing a network plan shall maintain a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week.*
While in general the Academy supports this definition, we urge NAIC to clarify two important issues. Firstly, in this requirement that a plan “shall maintain a plan that is sufficient” the Academy strongly believes that this “sufficiency” must be met regardless of what tier/level within a network a covered person may belong. The Academy is aware that plans often tier their networks and different benefits or access to different providers may be available based on what level of plan a covered person belongs. While this may be appropriate as a general plan of business, it is not appropriate that sufficient access to providers will vary by type of plan. The Academy strongly believes that all covered persons must have sufficient access to providers.

Secondly, we urge the NAIC to revise the definition to clarify that covered persons will have access to qualified providers. The value in access to providers will only be meaningful if covered persons have access to qualified providers. Board certification is often used as a proxy for minimum qualifications and it would be appropriate in this circumstance as well.

**The Academy urges NAIC to revise the definition of network adequacy and clarify that all covered persons regardless of network tier must have sufficient access to providers. Additionally, that these providers should be qualified and that board certification is an appropriate proxy for determining if a provider is qualified.** We believe that these changes will make the definition more robust and consequential.

**Sufficiency Standards**

In section 5B the criteria used to determine sufficiency are discussed. The document states:

> Sufficiency shall be determined in accordance with the requirements of this section, and may be established by reference to any reasonable criteria used by the carrier, including but not limited to:
> (1) Provider-covered person ratios by specialty;
> (2) Primary care provider-covered person ratios;
> (3) Geographic accessibility;
> (4) Geographic population dispersion;
> (5) Waiting times for visits with participating providers;
> (6) Hours of operation;
> (7) New health care service delivery system options, such as telemedicine or telehealth; and
> (8) The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care

The Academy appreciates the challenge to developing a list of criteria that are broad enough to address all situations but we find there are two significant omissions to the list that should be addressed.

We are pleased to see that the NAIC has acknowledged that ratios for primary care providers will be different than the ratios for specialists. We urge the NAIC to go further and delineate not just specialists but in some cases or for some at risk population also necessary “sub-specialists.” The Academy believes it is important that plans ensure that covered persons have access to specific key services within a specialty. For example, within ophthalmology there are specific preventive and therapeutic services that are essential for covered persons to have access to quality health care for their diseases. Annual screening for glaucoma and annual eye exams for diabetics are crucial for at risk populations. Once the specific services are identified,
it would be fairly easy to implement this policy by reviewing the previous year's claims data of
providers who are providing specific services to these populations within the network.

**Further, we suggest that a review of claims history in order to maintain access to the
necessary physicians for at risk population should be put forth as a separate drafting note.**

The Academy was very disappointed that specific quantitative standards were not included as
part of the reasonable criteria discussion in the revised Model Act. We understand the NAIC’s
rationale that such standards are typically included in regulations and not legislation.
Nevertheless, the absence of quantitative standards makes it even more necessary for these
general standards to be robust. The Academy urges NAIC to add language in the Model Act
encouraging states to adopt clearly defined, appropriate quantitative standards. In order to
ensure the validity of any adopted standards, they must be recognized; vetted; or approved by
a national or regional body.

**The Academy recommends that NAIC revise the reasonable criteria list to include provider-covered persons by specialists and the appropriate additionally trained subspecialists. We urge the NAIC to add criteria requiring plans to ensure that certain key services by specific specialties are being offered by providers within the network. Finally, the Academy strongly recommends that the NAIC add language in this section of the document urging states to adopt appropriate and clearly defined quantitative standards.**

**Access Plan**
Section 5F of the Model Act is a lengthy discussion of the access plan. This section covers a wide
variety of issues that should be included in an access plan such as coordination of care,
continuity of care, or addressing the needs of covered persons with limited English skills. What
does not address is the need for the access plan to address how the plan will identify,
develop, and implement quality standards for providers. In the current healthcare marketplace,
all providers are measured at some level by various quality criteria. In fairness to providers
and covered persons, plans should be transparent about how quality will be monitored.

**The Academy recommends that NAIC revise the list of topics to be included in the access plan so that it includes a requirement for access plans to include how plans will implement quality measurement of providers.**

**Access Plan Options**
Filing of an access plan should not in itself be a standard for determining network adequacy.
Timely filing, regulatory review and approval should be the mainstay of any requirement
regarding plan access and adequacy. NAIC should not provide a lesser option of simply filing an
access plan.

Furthermore, the access plan should contain the health plan's methods for ongoing assessment
and monitoring of adequacy and sufficiency within the all tiers of the network in order to
assure that the needs of enrollees within the network are met.

**Section 6 - Requirements for Health Carriers and Participating Providers**
Section 6 – Requirements for Health Carriers and Participating Providers contains the rights
and responsibilities of both plans and providers.
Selection Criteria

Section 6F(3) addresses selection criteria. The document states:

Selection criteria shall not be established in a manner:
(a) That would allow a health carrier to discriminate against high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services utilization; or
(b) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization;
(c) That fails to take into account provider performance on quality metrics and patient outcomes.

The Academy believes that this section raises a very important issue for both providers and covered persons. It acknowledges that certain providers because of geographic location or the populations they treat may be treating persons of higher risks. This section forbids plans to discriminate against such providers. We were surprised to see that this section also did not identify specialists and sub-specialists as also having higher risk patients and as a result potentially higher claim costs. **Ophthalmologists with additional training like other specialists often serve a subset of patients with very specific conditions that generalists refer to them. It is important that this type of bias is not held against additionally trained specialists when a plan is selecting a network.** The Academy urges NAIC to revise the language in this section to also specifically identify specialists including those with additional sub-specialty training to protect them against any potential selection bias.

Section 6F(3)(c) states that selection criteria shall not be established in a manner that “That fails to take into account provider performance on quality metrics and patient outcomes.” The development of quality measurement of healthcare services and providers is still in its infancy and there is great variation in the scientific soundness of the numerous measures that are available. Whenever possible, in this document when the issue of quality measurement is raised the Academy believes that the NAIC should promote nationally recognized measures.

The Academy recommends that section 6F(3) is revised to specifically identify that specialists and sub-specialists are not discriminated against in provider selection because of their potentially higher claims costs and that appropriate peer to peer comparisons take into account the appropriate mix and level of services when assessing quality and resource use. Additionally, the Academy urges the NAIC to revise section 6F(3)(c) so it references *nationally* recognized measures.

Availability of Information on Selection Criteria and Tiering

Section 6G addresses the issue of the availability of information on selection criteria and tiering. The document states:

A health carrier shall make its standards for selecting and tiering, as applicable participating providers available for review [and approval] by the commissioner.

The Academy recommends that this information should also be publically available. We urge the NAIC to revise the document to reflect this change. We believe that access to this
information would be valuable to covered persons and providers. Transparency of information has many benefits such as promoting accountability, relationship-building and can be an opportunity for the larger system to learn from the experience of individual qualified health plans.

**Termination**
Section 6L addresses the issue of termination of providers. The document states:

*A health carrier and participating provider shall provide at least sixty (60) days written notice to each other before terminating the contract without cause.*

Under the Medicare Advantage program, the Centers for Medicare and Medicaid Services (CMS) require 90 days notice whenever substantial changes are made to a Medicare participating health plan. The Academy believes a 90-day timeframe is a reasonable amount of time in order to allow for an appropriate transfer of care if necessary. There is also value in consistency around administrative rules between Medicare and private payors.

**The Academy recommends changing the required notice of termination to 90 days.**

While we understand that legally plans are allowed to terminate without cause at anytime, this can be very disruptive to patient care. The Academy also recommends the NAIC add language in this section of the document discouraging termination without cause in the midst of the plan year due to the potential negative impact it can have on patient care.

**Provider Directories**
Section 8 addresses the issue of provider directories. The Academy was very pleased with the addition of a requirement that directories should be updated monthly. Unfortunately, there was no language requiring plans to make any efforts to verify this data within the main document. There was reference to verifying the data in the drafting note. While the Academy was very pleased with the change to a monthly update of the directories, we believe that without a requirement to verify the data, the revision loses much value.

**The Academy strongly encourages NAIC to move the language around verifying the provider directory data from the drafting note to the main body of the document.**

We appreciate the opportunity to comment on the revisions to the Managed Care Network Adequacy Model Act. If you have questions or need any additional information, please contact Ms. Cherie McNett, AAO Health Policy Director at cmcnett@aaodc.org or via phone at 202-737-6662. Again, the Academy would like to thank you for providing us with the opportunity to comment and to work with NAIC.

Sincerely,

Michael X. Repka, M.D.
AAO Medical Director for Government Affairs