January 12, 2015

J.P. Wieske, Chair of the NAIC Network Adequacy Model Review (B) Subgroup
National Association of Insurance Commissioners (NAIC)
701 Hall of States
444 North Capitol Street, NW, Suite 701
Washington, DC 20001

Dear Mr. Wieske:

The Association for Community Affiliated Plans (ACAP) respectfully submits comments regarding the Draft Proposed Revisions to the Managed Care Plan Network Adequacy Model Act.

ACAP is an association of 59 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 24 states. Our member plans provide coverage to approximately 12 million individuals enrolled in Medicaid, the Children’s Health Insurance Program (CHIP) and Medicare Special Needs Plans for dually-eligible individuals. Nationally, ACAP plans serve roughly one-third of all Medicaid managed care enrollees. Seventeen of ACAP’s Safety Net Health Plan members have elected to offer qualified health plans (QHPs) in the Marketplaces in 2015.

Summary of ACAP’s Comments

The draft Network Adequacy Model Act covers a wide array of topics related to network adequacy; we have opted not to respond to all of them, but have restricted our comments to those issues that currently concern us most. The Model Act will be very helpful to states and HHS as they develop their own network adequacy requirements; we very much appreciate the effort that the Network Adequacy Model Review (B) Subgroup has put into the draft thus far. That said, we have identified a few sections of the draft Act for which are vague. Because of the attention the Act has and will continue to receive, it is critically important that these areas are clarified and reflect the complicated nature of provider data.

ACAP’s proposed language listed below is explained in greater detail later in the letter:

- **Carrier/Provider Contract Termination and Member Notification- 6L(1)(d):** *In instances where a provider does not notify the health carrier of their termination, the health carrier is responsible for making a good faith effort to notify covered persons being seen by the provider on a regular basis within thirty (30) days, after learning of and confirming the provider’s termination.*

- **Continuity of Care Provisions due to Active Treatment and Special Circumstance- 6L(2)(b)(ii):** *A health carrier shall agree to extend its obligation to reimburse the treating physician or provider for active*
treatment at the in-network rate if:

(i) The health carrier agrees that a condition for which ongoing treatment is being provided is part of a short-term agreement for enrollees undergoing active treatment; and

(ii) The contract termination was not “for cause.”

- Special Enrollment Period due to Provider Directory Inaccuracies- 6L Drafting Note: ACAP recommends that the drafting note be deleted.

- Monthly Update to Provider Directories- 8A(2): The health carrier shall update each network plan provider directory at least monthly after making a good faith effort to verify changes and shall be offered each provider directory in a manner to accommodate individuals with limited-English language proficiency or disabilities.

- Searchable Provider Directory- 8D: The requirement that the online directory be searchable for the features described in 8C shall go into effect two (2) years after this legislation is signed into law.

- Health Care Professionals’ Affiliations- 8C(1)(a): Hospital affiliations in the health carrier’s network;

- Health Care Professionals’ Affiliations- 8C(1)(b): Medical group affiliations in the health carrier’s network;

- Improving the Accuracy of Provider Directories- Drafting Note Proposed Language: In addition to requiring health carriers to update their provider directories at least monthly, to help improve the accuracy of the directories, states could consider the following: 1) a requirement that health carriers in some manner, such as through an automated verification process, contact providers listed as in network who have not submitted claims within the past six months for primary care providers and twelve months for specialists or some other time frame a state may feel is appropriate, to determine whether the provider still intends to be in network; 2) a requirement that health carriers internally audit their directories and modify directories accordingly based on audit findings to access: a) whether their contact information is correct, b) whether they are really in the plan’s network; and c) whether they are taking new patients; and 3) closely monitoring consumer complaints.

*Note: proposed language changes are both bolded and italicized.

ACAP’s detailed comments by Section are below:

Section 5: Network Adequacy

Quantitative Standards

Quantitative standards are discussed in the drafting note on page six of the Model Act. The draft Model Act does not include specific quantitative standards because the NAIC
subgroup felt that such standards are state-specific and more appropriate in regulation rather than in legislation. The drafting note says that “some states’ have developed specific quantitative standards to ensure adequate access that carriers must, at a minimum, satisfy in order to be considered to have a sufficient network.” The note includes examples of common network adequacy standards such as time and distance standards and also specifies that these requirements can vary by the type of service area e.g. rural or urban.

ACAP supports the approach the subgroup has taken in relation to network adequacy quantitative standards and the language in the drafting note. We believe that quantitative standards are not appropriate in the Model Act because each state and service area have their own concerns and challenges related to network access.

Section 6: Requirements of Health Carriers and Participating Providers

Carrier/Provider Contract Termination and Member Notification

Section 6L(1) requires both issuers and providers to provide at least a 60-day notice to each other before terminating their contract without cause. It also requires carriers to make a good faith effort to provide written notification of termination to all covered persons seen on a regular basis by a provider within 30 days of receipt or issuance of the notice of termination.

ACAP recommends adding a section (6L(1)(d)) that acknowledges that health carriers are not always immediately aware of provider terminations because the provider fails to notify the carrier of their termination, as our plans have found to be the case in some instances of provider termination. When the provider cannot or does not notify the carrier of their termination, the carrier may only learn of the provider’s termination when attempting to outreach to the provider, or the termination may be brought to the carrier’s attention via other means or from member notification. As written, Section 6L does not acknowledge this reality which can cause delayed notification to members of a provider termination.

ACAP’s 6L(1)(d) Proposed Language: In instances where a provider does not notify the health carrier of their termination, the health carrier is responsible for making a good faith effort to notify covered persons being seen by the provider on a regular basis within thirty (30) days, after learning of and confirming the provider's termination.

Continuity of Care Provisions due to Active Treatment and Special Circumstance

Beyond the provisions described above regarding provider and carrier notification in instances of contract termination, Section 6L includes continuity of care provisions.
Carriers are required to allow an enrollee in active treatment with a provider whose contract has been terminated without cause to continue treatment for up to 90 days or until the treatment is complete, whichever is less, 6L(2)(b). For individuals with special circumstances, section 6L(3) requires that a carrier extend its obligation to reimburse the treating physician and that providers agree to accept the in-network rate under the carrier’s provider contract (Section 6L(3)(b)-(c)).

We believe that a section should be added to (b) to clearly indicate that payment during the active treatment phase also be limited to the in-network rate.

**ACAP’S 6L(2)(b)(ii) Proposed Language:** A health carrier shall agree to extend its obligation to reimburse the treating physician or provider for active treatment at the in-network rate if:

(i) The health carrier agrees that a condition for which ongoing treatment is being provided is part of a short-term agreement for enrollees undergoing active treatment; and

(ii) The contract termination was not “for cause.”

**Special Enrollment Period due to Provider Directory Inaccuracies**

A drafting note under Section 6L recommends that states contemplate providing a special enrollment period for enrollees when a carrier’s provider directory is found to include a material error, inaccuracy or misrepresentation of the carrier’s provider network.

ACAP plans have reported that their provider directories are subject to change as often as daily. Under the drafting note, failure to immediately capture a change in the provider directory could provide an enrollee a special enrollment period. Although we see the need for allowing enrollees to have a special enrollment period when there is a gross misrepresentation in a carrier’s provider directory, the drafting note suggests that the special enrollment period could be available for any inaccuracy. The allowance of a special enrollment period for such a change creates an opportunity for confusion and breaks in coverage as well as degradation of the risk pool for potentially minor inaccuracies. In addition, the drafting note is not in agreement with the requirement that provider directories be updated monthly, 8A(2).

Although suggestion of the special enrollment period is only found in a drafting note, the Model Act is being looked towards by CCHIO as they undergo establishing new standards related to network adequacy. ACAP believes that this drafting note should be struck from the Model Act because of how often provider directories are subject to change and its ultimate impact on the commercial risk pool. However, if the drafting note does remain, we propose clarifying that it only applies to gross inaccuracies or where there is failure of the plan to meet the requirement for timely provider updates.
ACAP's Drafting Note Proposed Language: States may want to review other state laws and regulations and consider adding to them special enrollment periods to address potential issues consumers may face, particularly with respect to continuity of care issues, when a consumer’s enrollment or non-enrollment in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in a provider directory, including when a provider is listed as a participating provider, but subsequently is found not to be an in-network or a participating provider is listed as accepting new patients.

Section 8: Provider Directories

Monthly Update to Provider Directories

Section 8A(2) specifies that a health carrier must update its provider directories at least monthly. ACAP is supportive of this requirement but we believe it must be further specified that only verified changes related to the provider directory should be included in the monthly update. As described above regarding contract terminations, carriers are not always notified when there is a provider termination or change in provider information, such as updates of contact information and affiliations. Our suggested language protects carriers from being required to update provider directories in instances where they were not notified or unable to verify a provider directory related change prior to the monthly update.

ACAP’s 8A(2) Proposed Language: The health carrier shall update each network plan provider directory at least monthly after making a good faith effort to verify changes and shall be offered the provider directory in a manner to accommodate individuals with limited-English language proficiency or disabilities.

Searchable Provider Directory

Section 8C specifies the information that must be included and searchable as part of a health carrier’s online provider directory. The information required to be searchable includes: hospital and medical group affiliations (see comment below), board certification(s), languages spoken by the health care professional or clinical staff; location(s), name, facility type and procedures performed.

ACAP supports the requirement that provider directories be searchable but asks the subgroup to consider that some carriers, including some Safety Net Health Plans, do not currently have the technology to access all of this information via a search function. We request that language be included in the Model Act delay that would delay the search function requirement for two years after the Act is adopted and signed into law, giving plans adequate time to implement the appropriate technology.
ACAP’s 8D Proposed Language: The requirement that the online directory be searchable for the features described in 8C shall go into effect two (2) years after this legislation is signed into law.

Health Care Professionals’ Affiliations

Section 8C(1)(a) requires that health carriers include health care professionals’ hospital and medical group affiliations as part of their provider directory. This requirement has the potential to cause member confusion because the provider may be affiliated with hospitals and groups that are not in the health carrier’s network. For example, if the covered person were to be seen by the contracted provider at a non-contracted facility, the covered person may have facility-related costs associated with the services received that would not be covered by the health carrier. To reduce potential confusion related to the affiliations listed in the provider directory, ACAP recommends this requirement specify that only those affiliations in the health carrier’s network should be included as affiliations in their provider directory.

8C(1)(a) Proposed Language: Hospital affiliations in the health carrier’s network;

8C(1)(b) Proposed Language: Medical group affiliations in the health carrier’s network;

Improving the Accuracy of Provider Directories

The Drafting Note on page 15 suggests that states should consider requiring health carriers to contact all providers that have not submitted claims in six months to verify that the provider still intends to be in the network. ACAP believes that while six months may be a reasonable standard for primary care providers, the timeline should be extended to twelve months for specialists. Our plans have found that it is common for some specialists to go for six months or longer without submitting a claim; the requirement that a carrier contact all of these specialists every six months creates an undue burden and could result in viable network providers being dropped from the provider directory. ACAP suggests that the drafting note reflect this reality.

ACAP’s Drafting Note Proposed Language: In addition to requiring health carriers to update their provider directories at least monthly, to help improve the accuracy of the directories, states could consider the following: 1) a requirement that health carriers in some manner, such as through an automated verification process, contact providers listed as in network who have not submitted claims within the past six months for primary care providers and twelve months for specialists or some other time frame a state may feel is appropriate, to determine whether the provider still intends to be in network; 2) a requirement that health carriers internally audit their directories and modify directories accordingly based on audit findings to access: a) whether their contact
information is correct, b) whether they are really in the plan’s network; and c) whether they are taking new patients; and 3) closely monitoring consumer complaints.

Conclusion

ACAP thanks you for your willingness to discuss these issues with us. If you have any additional questions or comments, please do not hesitate to contact Deborah Kilstein (202-341-4101), dkilstein@communityplans.net).

Sincerely,

Margaret A. Murray
Chief Executive Officer