Qualified Health Plans: Provider Network Issues for Qualified Health Plans

Peter Lee and Andrea Rosen
California Health Benefit Exchange
Sandra Hunt
PricewaterhouseCoopers

July 26, 2012, 4:30-6:00 PM
California Health Benefit Exchange Webinar

Qualified Health Plans
Plan and Network Design Issues

Provider Network Access: Adequacy Standards

The California Health Benefit Exchange is considering options related to how it will assure that those who enroll in Qualified Health Plans have access to sufficient health care professionals trained in a range of skills and specialties. To do this, the Exchange is assessing the extent to which its requirements for network adequacy meet or exceed those required by current regulation of health plans under the California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI).

1. Consideration of Exchange Provider Network Access Adequacy Standard for QHP Certification		
Option A: Adopt regulatory requirements of Qualified Health Plans bidder's current regulatory agency	**Option B: Adopt regulatory requirements of DMHC for all Qualified Health Plans bidders**	**Option C: Adopt additional Exchange-specific standards for all Qualified Health Plan certification above and beyond the regulators respective provider network adequacy standards**
Continues current regulatory requirements (e.g., PPO's regulated by CDI would comply with the Insurance Code and HMO's/PPO's regulated by DMHC would comply with the Health and Safety Code	Establishes an HMO provider network adequacy and access standard for QHPs licensed under CDI	Establishes a more rigorous provider network adequacy and access standard for all QHPs different from current standards
Preliminary Recommendation: Adopt current regulatory requirements, Option A		

Provider Network Access: Adequacy Standards

2. Approaches to Evaluating Provider Network Adequacy for QHP Certification		
Option A: The regulator – DHMC or CDI – certifies a Qualified Health Plan bidder's network complies with the applicable network access standard	**Option B: The Exchange requires regular additional provider network surveys or analysis for all Qualified Health Plans to benchmark or to monitor potential areas of concern**	**Option C: The Exchange requires increased frequency and detail in geo-access reporting**
Adopts the provider network adequacy monitoring requirements applicable to the existing license of the issuer for the Qualified Health Plan	Adopts the additional provider network adequacy monitoring requirements applicable to the existing license of the issuer for the Qualified Health Plan May be by type of specialty, by region or by other provider characteristics	Adopts more frequent provider network adequacy monitoring requirements applicable to the existing license of the issuer for the Qualified Health Plan May be by type of specialty, by region or by other provider characteristics

Preliminary Recommendation : Regulator applies network adequacy standard and certifies compliance, Option A

Essential Community Providers: Standards

Exchange Qualified Health Plans will serve many low and modest income persons starting in 2014. Some of these people traditionally have been served by "essential community providers" - provider organizations that by legal obligation, organizational mission, or geographic location serve a patient population that has been at risk for inadequate access to care. The California Health Benefit Exchange is considering the options related to the definition and "sufficient participation" of Essential Community Providers as well as payment mechanism to Federally Qualified Health Centers.

1. Definition of Essential Community Providers	
Option A: Define Essential Community Providers as the minimum standard limited to the list of 340B and 1927 providers	**Option B: Incorporate minimum standard of Option A and broadens the list of Essential Community Providers to include physicians, clinics and hospitals which have demonstrated service to the Medi-Cal, low-income, and medically underserved populations.**
Adopts the definition of Essential Community Provider used in the Federal Law and additional regulations to include Section 340B and 1927 providers	Expands the definition of Essential Community Provider to include private practice physicians, public and private clinics and any hospitals that have traditionally served Medi-Cal and other low-income populations. Exchange establishes criteria for QHPS to use to identify providers that meet the definition of Essential Community
Preliminary Recommendation: Adopt a broad definition of Essential Community Providers, Option B	

Qualified Health Plans
Plan and Network Design Issues

Essential Community Providers: Standards

2. Definition of "Sufficient" Participation of Essential Community Providers	
Option A: Qualified Health Plans may use existing regulatory network access criteria to demonstrate Essential Community Provider network adequacy based on low-income target population	**Option B: Demonstrate minimum proportion of network overlap between Qualified Health Plan network and Medi-Cal Managed Care, Healthy Families Program networks and/or independent physician providers serving a high volume of Medi-Cal patients in their practices**
Adopts the existing regulatory framework for network adequacy and applies it to Essential Community Providers	Requires plans to demonstrate sufficient participation of Essential Community Provider by illustrating overlap between Essential Community Providers and the region's low income population (see brief for definition).
Preliminary Recommendation: Demonstrate network overlap in low income areas, Option B	

Essential Community Providers: Standards

3. Payment Rates to Federally Qualified Health Centers		
Option A: Require QHPs to contract with all FQHCs and mandate payment under terms of section 1902(b) of the Act or the PPS rate	**Option B: Encourage inclusion of FQHCs in Qualified Health Plan provider networks and require payment under terms of section 1902(bb) of the Act- at the PPS rate**	**Option C: Encourage inclusion of FQHCs in Qualified Health Plan networks and require payment at fair compensation by the Qualified Health Plan defined as rates no less than the generally applicable rates of the issuer**
Maximum participation of Federally Qualified Health Centers at preferred Medicaid Prospective Payment System rate	Recognizes autonomy of health plan to determine what provider it will contract with to meet sufficient Essential Community Provider participation requirement	Recognizes autonomy of health plan to determine what provider it will contract with to meet sufficient participation requirement at payment rates that contributes to an affordable product

Preliminary Recommendation: Include FQHCs with payment at fair compensation, Option C.

Qualified Health Plans

Comments and Input Welcome

- Comments welcome on Board Recommendation Brief materials
- Please submit comments on the Stakeholder Input form by COB, Monday, August 6
- Send comments to info@hbex.ca.gov
- See the Stakeholder section of the Exchange Website for response form