Network Adequacy Rulemaking

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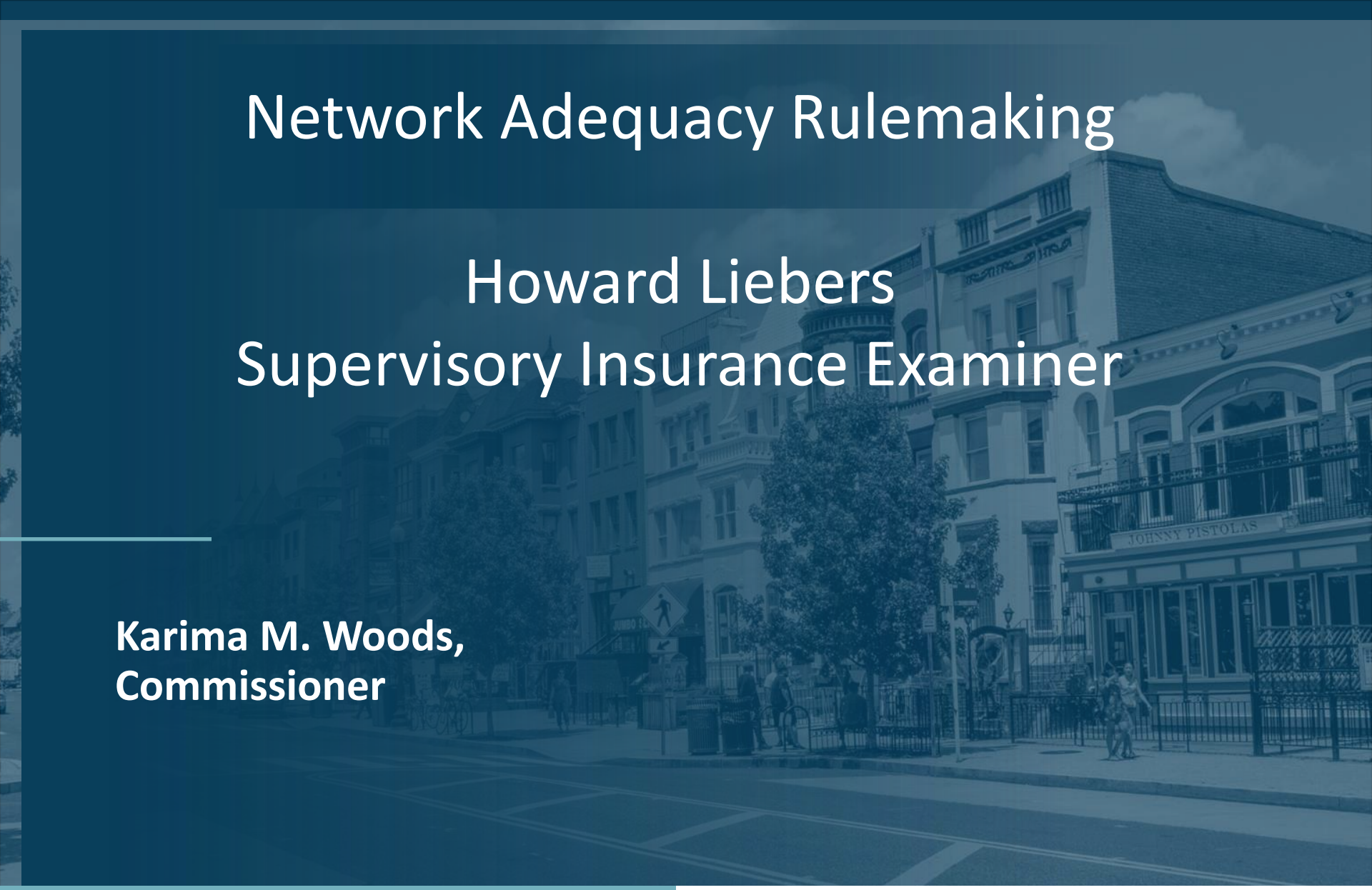

Karima M. Woods,
Commissioner

March 1, 2023

DISB | GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

WHO WE ARE

- DISB regulates financial services businesses in the District by administering District of Columbia insurance, securities and banking laws, rules, and regulations.

- Our mission is threefold:

  - Cultivate a regulatory environment that protects consumer and attracts and retains financial services firms to the District
  - Empower and educate residents on financial matters
  - Provide financing for District small businesses

BACKGROUND

No national standards for network adequacy for all health plans

- Federal government certifies Qualified Health Plans (QHP's) for 30 states and would enforce some federal standards for them; although beginning with the 2018 plan year, the Trump Administration ended direct federal oversight of the adequacy of QHP networks, deferring to state oversight, accreditation by private organizations, or the issuer's attestation. A federal court subsequently ruled this change was arbitrary and capricious, and as a result, federal oversight is scheduled to resume for the 2023 plan year
- DC has a state-based exchange and enforces standards for plans sold on DC Health Link (individual and small group insurance markets); DISB and HBX do much of the work on that together;
- DISB will enforce standards for other plans (large group insurance market); and work with DHCF on Medicaid.

BACKGROUND

DISB First Proposed Rulemaking in DC Register

11/23/2018 Vol 65/48

DISB 2nd Proposed Rulemaking in DC Register

7/29/2022 Vol 69/30

DISB Final Rulemaking

2/17/2023 Vol 70/7

N129228	26-A4700	Insurance, Securities and Banking, Department of - Notice of Final Rulemaking - Adopting 26 DCMR Ch. 47 - Health Benefit Plan Network Access and Adequacy		2/17/2023 Vol 70/7	2/17/2023

BACKGROUND

For marketplace plans beginning in 2023, CMS has proposed time/distance standards for various types of providers and facilities. At least 90 percent of enrollees must live within the maximum distance to at least one provider of each type.

CMS 2023 Draft Letters to Issuers in the Federally-facilitated Exchanges.

Another type of standard sets maximum appointment wait-times for certain types of services. CMS has proposed this standard for 3 types of outpatient appointments shown below. Issuers would attest that 90% of contracted providers meet the wait-time standard; CMS would conduct compliance reviews in response to complaints and random audits. CMS has not proposed to create a complaints hotline for federal marketplace enrollees.

Proposed Appointment Wait Time Standard for Federal Marketplace Plans, 2023	
Provider Type	**Appointments must be available within:**
Behavioral Health	10 calendar days
Primary Care (routine)	15 calendar days
Specialty Care (non-urgent)	30 calendar days

Source: 2023 Draft Letter to Issuers in the Federally-facilitated Exchanges

DISB RULE: 4701 – APPLICABILITY & SCOPE

4701.1 Except as provided in § 4701.2, this chapter applies to all health carriers that offer network plans, including Medicaid.

4701.2 These rules shall not apply to health carriers that offer network plans that consist solely of limited scope dental plans or limited scope vision plans.

DISB RULE: 4702 – NETWORK ADEQUACY

- Network Adequacy Report Due **Sept 1** each year for plans sold, issued, renewed on or after **Jan 1** of the subsequent year
- First ‘plan year’ will be 2024, so reports due Sept 1, 2023.
- Some separate requirements for closed vs open provider network (e.g. Kaiser), specifically ratios of providers to enrollees
- provider-to-covered person ratios are 1:7,500 for specialists & 1:3,000 for primary care / pediatrics / OB-GYN / behavioral health / hab services for closed networks, and 1:5,000 & 1:2,000 respectively for open networks

DISB RULE: 4702 – NETWORK ADEQUACY

- Appointment wait times:
  - First Appt with new or replacement Primary Care: 7 business days
  - First Appt with new or replacement MH/SUD: 7 business days
  - First Appt with new or replacement Prenatal: 15 business days
  - First Appt with new or replacement Specialty: 15 business days

- This info needs to be communicated in welcome packet, and post/link in online provider directory pages.
- Carriers will have a call center to help enrollees get appointments & will report on call center activities in the Network Adequacy Report

DISB RULE: 4702 – NETWORK ADEQUACY

- Accessibility:
  - Commissioner to provide list of providers with primary practice address within 1/2 mile of a metrorail stop & carriers have to contract with minimum of 30% to be within their network for each specialty AND 30% of the total providers on the list

    (15% for closed network model)
  - This has not yet been completed, but the Department intends to release this by March 1 of each year (or carriers may use the prior years if the Dept doesn't issue a new one)
  - Carriers shall have procedures to allow enrollees to get covered benefits from non-participating providers at in-network benefit levels when certain conditions are met.

DISB RULE: 4703 – ACCESS PLAN

There will be one initial Access Plan from each carrier (different, separate & apart from the Network Adequacy Report), which is then updated annually when there are material/substantive changes to the network, for example:

- 10% or greater change in total number of network providers
- 20% or greater reduction in number of primary care providers
- Increase or decrease of 20% or more covered persons

Access Plans will include descriptions of:

- Use of telemedicine to enhance access
- Procedures for making referrals
- Efforts to address needs (children vs adults; literacy; diversity; disabilities)
- Informing enrollees about processes: Grievances & Appeals, Updating Provider Directories, Covering & Approving emergency / urgent / specialty care
- Provider / Carrier contract terminations & continuity of care

DISB RULE: 4704 – CARRIER & PROVIDER RELATIONSHIPS

- Hold harmless provisions (language consistent with used in MD)
- Provider's obligation to deliver covered services without balance billing in the event of carrier insolvency or other cessation of operations until termination of enrollees' coverage or the date the contract expires
- Prohibits carrier network selection standards from discrimination, adverse tiering, acting within the scope of provider license
- Provider's responsibilities related to payment terms, provider directory updates, utilization review, credentialing, grievances, etc.
- 60 Days notice before provider removed from network without cause

  & 30 Days notice to enrollee of provider's removal/withdrawal
- Provider is terminated with cause, allows an enrollee to continue treatment for 90 Days at in-network cost-sharing rates.

DISB RULE: 4705 – PROVIDER DIRECTORIES

- Specifies the data which should be available (name, gender, language, ADA accessibility, facility affiliation, etc).
- To ensure accuracy:
  - Provide email/phone that the public may use to notify of inaccuracies
  - Maintain a log of 2 years of inaccuracies reported to the carrier
  - Validate reports of inaccuracies/incompleteness and correct info within 30 Days
  - Quarterly review for providers who have not filed a claim within 2 years or more
  - Minimum annual audit of at least 15% of providers in specialties listed in the rule

RESIDENTS CAN CONTACT DISB THROUGH VARIOUS PLATFORMS INCLUDING:

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disb.dc.gov

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Our office is located at 1050 First Street NE
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THANK YOU

DISB | WE ARE WASHINGTON DC GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR

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