Rural Health and Network Adequacy

RWHC Eye On Health

“Your insurance covers the bed as ‘in-network’ but not the room.”

Tim Size
Executive Director
Rural Wisconsin Health Cooperative
Sauk City

"Weekly Office Hours"

Federal Office of Rural Health Policy

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Outline of Network Adequacy Overview

1. Network Adequacy: Context, Values and Issues
2. U.S. to Become More Like WI & CA?
3. Pros/Cons of Health Plan “Outreach”
4. ACA Regulatory Requirements
5. Going Forward
“Network adequacy refers to a health plan's capacity to serve its members with quality, cost-effective and reasonably accessible care.

Narrow networks, excluding some providers, are not new but are increasing due to the Affordable Care Act.

Source: “Network Adequacy and Rural Communities,” by Mike Vanderboom, J.D., with the Rural Wisconsin Health Cooperative available at www.rwhc.com
“Although rural opportunities exist to improve care and share in cost savings, rural providers are also at risk from any predatory systems that do not adequately value rural community health and vitality.”

Network Adequacy: Proposed Values

- **Transparency and Consumer Engagement.** Consumers must have the ability to determine which providers are in the network and which are accepting new patients.

- **Choice.** Consumers must have access to a choice of insurers and providers.

- **Accessibility.** Consumers must have access that reflects “historical patterns of care” and/or improved practices and standards of care in their community.

- **Affordability and Cost Effectiveness.** Network adequacy standards must not result in unaffordable health insurance costs.

Source: Wisconsin Hospital Association Network Adequacy Council
Network Adequacy: Examples of “Issues”

- Health plan does not offer a contract with any hospital in the county.
- Health plan offers a contract at Medicaid rates or admit that they really don’t need or want a contract.
- Health plan has contracted with the hospital, but does not contract with or credential all physicians employed by the hospital.
- Hospital has a contract with health plan, but no one is referred to the hospital.
- Health plan contracts with community clinic, but not the specialists or hospital affiliated with the community clinic.
- Contracted providers are not consistently listed as available.

Source: Wisconsin Hospital Association Network Adequacy Council
However, in recent years, the majority of the enrollment in PFFS plans has shifted to PPO plans in rural areas. The ACA created quality-based bonus payments for MA plans with ratings of 4.0 stars or higher. Using this rating level as a dividing line, a higher proportion of urban MA enrollees (36.0% compared to 31.6% in rural areas) are enrolled in an MA plan that receives a bonus payment. However, nearly all MA enrollees both in rural areas (91.9%) and in urban areas (94.4%) are in plans with a quality rating of 3.0 stars or higher (Figure 2), qualifying them for bonus payments under the current demonstration program. Nearly one-half (49.8%) of rural HMO enrollment is in a plan with a 4.0-star or higher rating, while only 24.7% of rural PPO enrollment is in such a plan. The majority (73.6%) of rural PPO enrollment is in plans with an average quality rating of 3 or 3.5 stars. Many rural Medicare beneficiaries have limited access to MA plans and in some areas do not have an HMO option available to them, leaving them with PPO plans as their only option.

Figure 2. Percentage of Plans and Enrollment by MA Plan Star Rating and Location, 2012

The quality rating of rural MA plans varies significantly across the country, with the highest quality ratings in rural areas in Minnesota, Iowa, Wisconsin, Oregon, Pennsylvania, and Maine (Figure 3). MA beneficiaries in southern and some central midwestern rural areas are, in general, enrolled in MA plans with lower quality ratings. Ratings are aggregate measure of clinical outcomes & process, patient experience & access.
HMO Market Share by State

Source: Kaiser Family Foundation (7/13)
National Average = 23.5%
Managed Care Penetration

Source Data: State of Wisconsin; Office of Commissioner of Insurance, 9/14

Map: Wisconsin Office of Rural Health
Wisconsin

47 of 72 counties are “Non-Metro” spread throughout the state with 28% of the state’s population.

There are 58 CAHs in Wisconsin and about 10 Tweeners (smaller rural PPS hospitals).
3. Pros/Cons of Health Plan “Outreach”

Network Adequacy not a new issue but it has accelerated with the Affordable Care Act.

Narrow networks create a natural tension between insurers and providers—between driving down costs vs. providing access to care locally.

“‘Being a national player’ sounds a lot better than ‘eliminating local competition’.”
Managed Care Plans* – “South-Central”

Dean
(Dean-SSM)

Group Health Cooperative
(GHC)

Physicians Plus
(UnityPoint)

Unity
(UW)

250,623

69,962

63,797

153,250

“Total Enrollment by Company” As of January 1, 2014

Managed Care Health Plans In Wisconsin, revised 9/14

*Partial List and Maps are as of 2013
Managed Care Plans* – “South-West”

Health Tradition (Mayo)

Gundersen (Gundersen)

Medical Associates (Med Assoc.)

34,987

55,087

5,946

“Total Enrollment by Company” As of January 1, 2014

Managed Care Health Plans In Wisconsin, revised 9/14

*Partial List and Maps are as of 2013
Managed Care Plans* – “North-East”

Compcare (BCBS now Anthem)

UHC of Wisconsin (United)

Network (Affinity)

169,263
252,703
142,203

“Total Enrollment by Company” As of January 1, 2014
*Partial List and Maps are as of 2013
Managed Care Plans* – “North-West”

Compcare (BCBS now Anthem)  169,263
Security (Marshfield Clinic)  199,248
Group Health Coop of Eau Claire  39,783
Health Tradition (Mayo)  34,987

“Total Enrollment by Company” As of January 1, 2014
*Partial List and Maps are as of 2013
4. ACA Network Adequacy Requirements

The Affordable Care Act (ACA) requires health plans to include “a sufficient number and geographic distribution” of ‘essential community providers.’

A Model Act is being developed by the National Association of Insurance Commissioners and is likely to significantly influence the development of state standards.

“We used to have a doctor and no insurance; now we have insurance and no doctor.”
“Reasonable Access” Is a Work in Progress

Network adequacy within the ACA is fundamentally related to the process by which the Exchanges certify Qualified Health Plans (QHPs).

CMS assesses provider networks using a “reasonable access” standard, and theoretically identifies networks that fail to provide access without unreasonable delay.

CMS intends to use information learned during the Qualified Health Plan Application process to assist in its articulation of time and distance or other standards for FFM QHP networks that CMS intends to reflect in future rulemaking.

Source: CMS “2015 Letter to Issuers in the Federally-facilitated Marketplaces “
Essential Community Provider (1 of 2)

“For benefit year 2015, CMS will utilize a general Essential Community Provider (ECP) enforcement guideline whereby if an application demonstrates that at least 30 percent of available ECPs in each plan’s service area participate in the provider network, it will consider the issuer to have satisfied the regulatory standard.”

In addition CMS expects that the issuer offer contracts in good faith to listed ECPs. I.e. “a contract should offer terms that a willing, similarly-situated, non-ECP would accept or has accepted.”

Source: CMS “2015 Letter to Issuers in the Federally-facilitated Marketplaces “
Listed ECP Providers include all available Indian health providers in the service area and at least one ECP in each ECP category in each county in the service area, where an ECP in that category is available.

**ECP Categories:** FQHC, Ryan White Providers, Family Planning Provider, Indian Health Providers, Hospitals

**As an example of ECPs within one category:** Hospitals include DSH and DSH-eligible Hospitals, Children’s Hospitals, RRCs, SCH, Free-standing Cancer Centers, CAHs

Source: CMS “2015 Letter to Issuers in the Federally-facilitated Marketplaces “
5. Going Forward

“Rural providers and their communities should proactively prepare for a health care future increasingly requiring interdependence, collaboration, and accountability.”

How Can We Be Proactive Locally? (1 of 2)

- Track specific examples of rural care deficiencies created by network inadequacies.
- Engage the plans themselves in conversation about the tracked identified health care inadequacies and attempt to develop solutions collaboratively with those plans outside of the regulatory process.
- If unsuccessful in reaching a collegial resolution with the health plan, present clear and organized evidence of network inadequacy to regulators, keeping the plan in the loop.

Source: “Network Adequacy and Rural Communities,” by Mike Vanderboom, J.D.
How Can Rural Be Proactive Locally? (2 of 2)

- Monitor upcoming state legislation addressing network adequacy and submit evidence-based commentary.

- Engage rural communities in raising awareness - educate and broadcast this important message in plain language.

Source: “Network Adequacy and Rural Communities,” by Mike Vanderboom, J.D.
What Train Are We Trying to Catch?

“Ultimately, an ‘adequate’ network is subjective, based on the varying needs and perspectives of consumers, providers, and insurers.”

“However, insurers should be regulated in a manner that effectively addresses rural network adequacy.”

“To achieve this goal, those promoting this result will need to significantly raise awareness on this issue.”

Source: “Network Adequacy and Rural Communities,” by Mike Vanderboom, J.D.
For More Information

“Well Network Adequacy in Rural Wisconsin” is a 20 page discussion paper developed by Mike Vanderboom, J.D. with the Rural Wisconsin Health Cooperative while Mike was a clinical legal intern from the University of Wisconsin Law School.

This review is not the definitive word on the subject but intended to help accelerate early understanding and action on this issue critical to the future of rural health during an age of accelerating “reform.”

The policy brief is available at www.rwhc.com or download directly from http://ow.ly/I0zZT

A PDF of this PPT is also available at www.rwhc.com