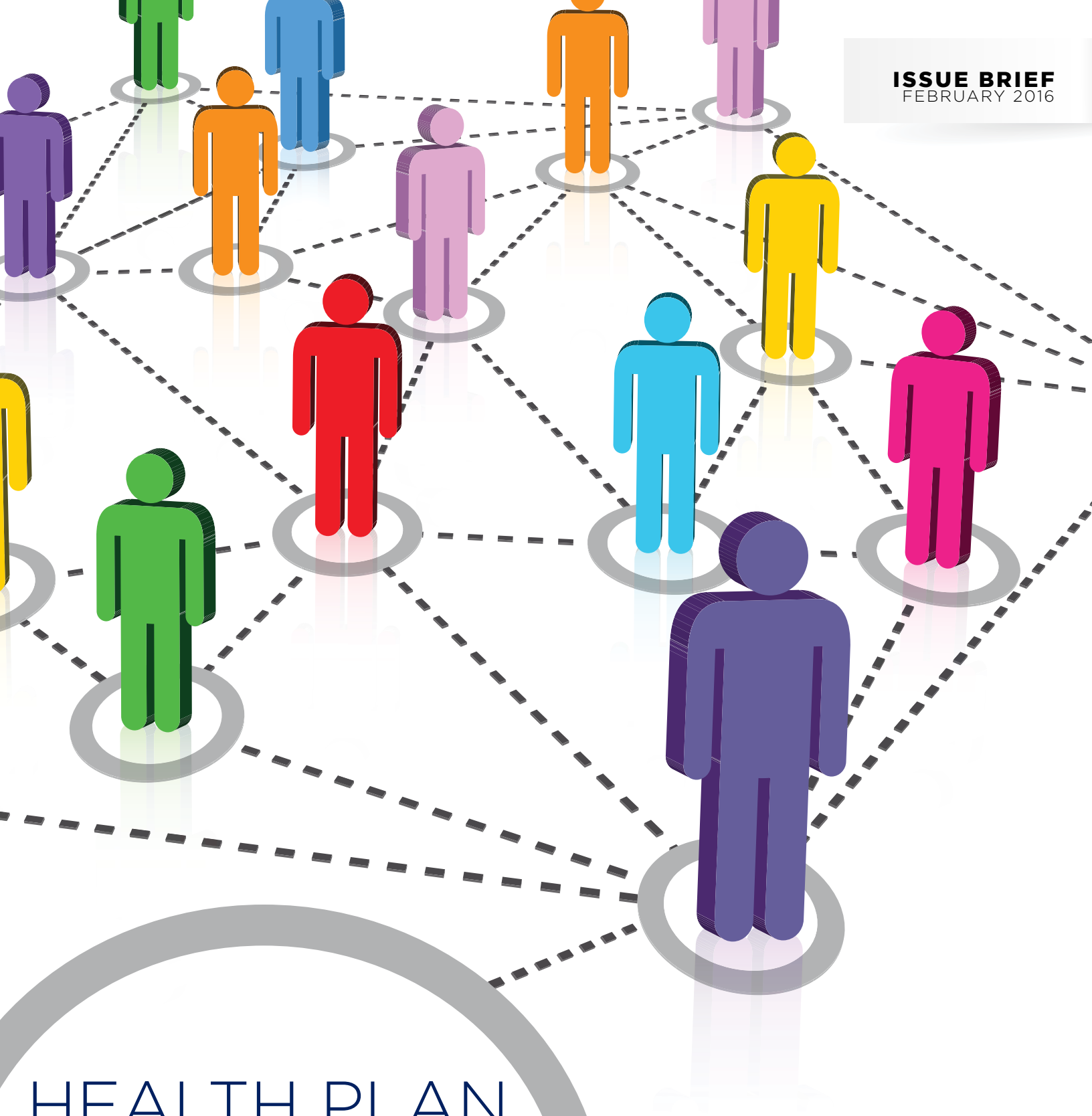

ISSUE BRIEF
FEBRUARY 2016

HEALTH PLAN NETWORK ADEQUACY

How URAC Accreditation Aids Consumer Protection

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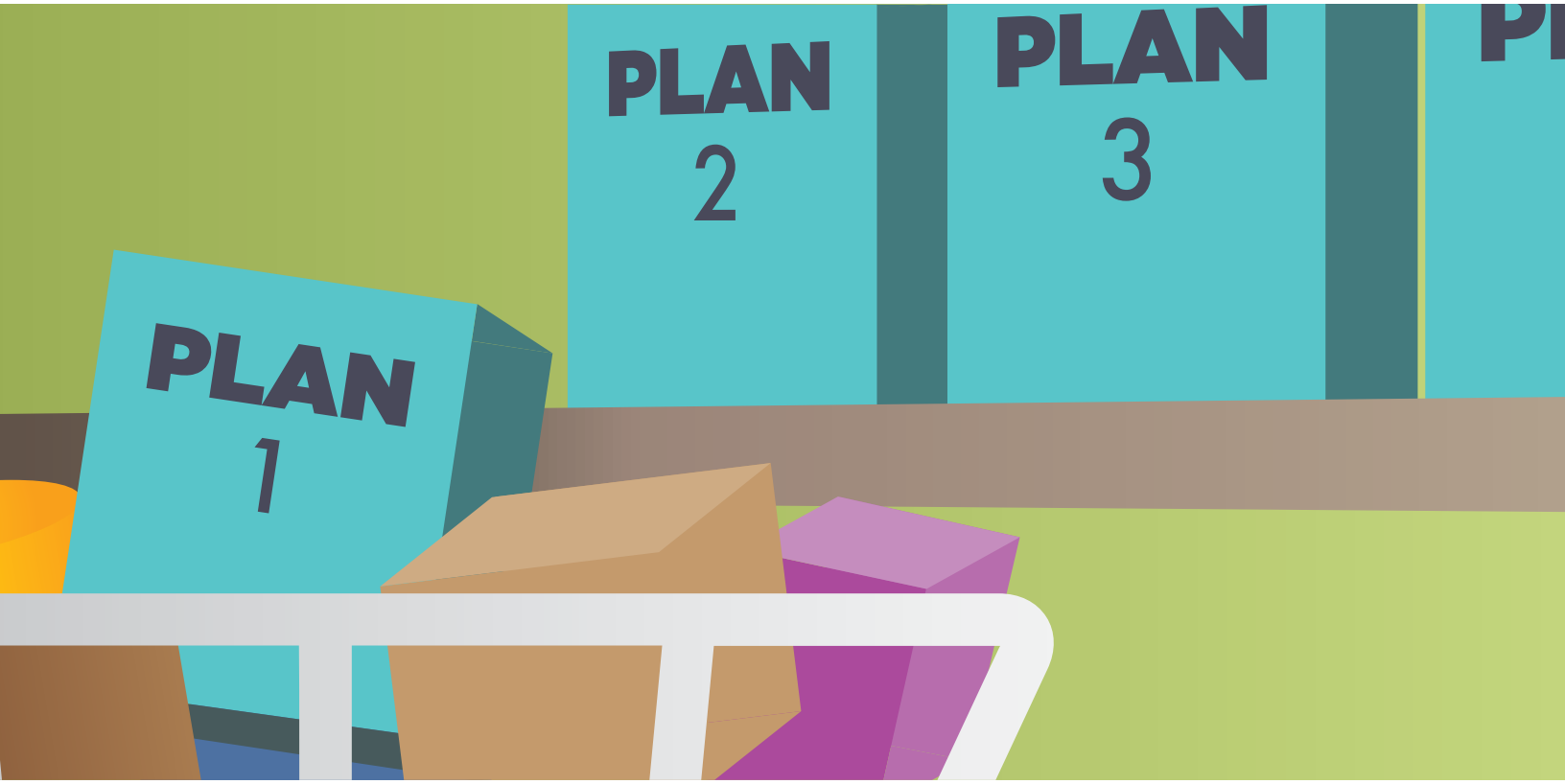

INTRODUCTION |

As consumers continue to enroll in health plans through Health Insurance Marketplaces, there is concern about the adequacy of provider networks created by Qualified Health Plans (QHPs).

This issue brief examines consumer protection principles underlying URAC's Health Plan Accreditation standards that address the network adequacy requirements of QHPs. URAC standards that support the best practices highlighted in this brief are also utilized by non-marketplace health plans.

URAC's Health Plan Accreditation standards reflect industry practices for the development, management, and evaluation of a health plan's network of providers. Because URAC believes all health care is local, the approach to network adequacy in its Health Plan accreditation standards is not limited to time and distance or the number of providers in a geographic area. The most important principle of access is meeting the needs of the local communities served. Topography and geography are equally important determinants of appropriate access to care. Additionally, consumer protections go hand in glove with adequate access.

URAC believes that a standard based on meeting community need is superior to simply adhering to an arbitrary number representing a single point in time.

Because the two most commonly accepted formulas for the minimum number or types of providers to be included in a network do not work for every community, URAC standards are intended to help a health plan create a system to monitor its network and confirm that it meets the clinical needs of its enrolled population. Provisions in URAC network management standards (see page 3) require evidence of ongoing oversight of network adequacy by a health plan's quality improvement program.

Furthermore, URAC standards safeguard consumers' rights to actively participate in their care and have access to a formal complaint and appeal process within their health plan. Accreditation processes validate that health plans have active complaints and appeals procedures for patients and those working on their behalf.

OVERVIEW |

All URAC accreditation programs include a robust emphasis on consumer protection and patient safety. Internal audits of health plan operations examine whether consumer needs and patient safety are evaluated and addressed on an ongoing basis. URAC accreditations include - consumer protection principles that support network management standards:

- Health plans must have written plans for recruiting clinicians to their network, credentialing providers, and managing their provider network.
- Health plans are responsible for documenting the geographic and demographic make-up of their enrollee populations as well as creating provider networks accessible to the communities they seek to serve and deliver quality care.
- Consumers must receive clear communications on how to access care both within and outside the network.
- Consumers must have access to complaint and appeal processes addressing situations when a consumer has difficulty finding a provider or making an appointment as well as when a consumer has issues regarding financial responsibilities for out-of-network care.
- Health plans must review data and consumer feedback on an ongoing basis that could indicate problems with the quality, access, or availability of their provider network.

AFFORDABLE CARE ACT NETWORK ADEQUACY REQUIREMENTS |

The Affordable Care Act (ACA) requires QHPs to guarantee their provider network:

- includes essential community providers;
- maintains a provider network sufficient in the number and types of providers – including mental health and substance abuse services;
- ensures all services can be accessed without unreasonable delay; and
- prohibits limiting enrollees' benefits or access to providers based on health status-related factors.

States often have additional regulatory requirements regarding network adequacy. These common formulas typically require that health networks include a specific number or type of providers in their network or meet specific time and distance standards. This is especially common in Medicaid and Medicare managed care programs.

HOW URAC STANDARDS ADDRESS NETWORK ADEQUACY |

Accrediting bodies recognized by the U.S. Department of Health and Human Services such as URAC are responsible for confirming that issuers of QHPs have formal policies, procedures, and systems in place to address all regulatory and Health Insurance Marketplace requirements. A compliance program is also required to manage ongoing adherence of applicable statutes and regulations by accredited health plans.

QHP compliance programs, for instance, must address monitoring of medical network, timely access to care, panel and provider availability, and responses to

enrollee complaints. If the QHP's performance is found to be deficient during the accreditation review, URAC oversees the development and successful completion of a corrective action plan. Furthermore, URAC warrants that the organizations it accredits have proper mechanisms in place to build, manage, and evaluate their networks with respect to the needs of the populations they seek to serve.

URAC's Health Plan Accreditation standards incorporate requirements that directly address network management. QHPs must conduct surveys of member experiences with their plan and network providers. QHPs must also maintain an accurate online provider directory that clearly indicates those not accepting new patients. URAC standards also require QHPs to communicate patients' appeal rights and responsibilities in plain language so enrollees understand their options.

HOW URAC STANDARDS ADDRESS NETWORK MANAGEMENT |

Specifically within URAC's standards for network management:

- URAC Scope of Services Standard P-NM 1 requires an organization define the scope of its services with respect to the types of services offered within the provider network as well as the geographic area served.
    - ◊ The URAC scope of services standard confirms that a plan has a process in place to establish and assess the requirements of the service area for both population demographics and the geographic area served by a network. Variation in geography is a significant determinant of network adequacy decisions in rural America and places where topography creates its own challenges.
- URAC Access and Availability Standard P-NM 2 requires that a provider network establish goals, measure results, and report actual performance in comparison to those goals to its Quality Management Committee (QMC). It must then make improvements, where necessary, to maintain the provider network and meet contractual requirements.
    - ◊ URAC applicant organizations are reviewed to confirm they have an active internal control system in place to support compliance with state and federal network adequacy regulations.
    - ◊ This standard requires a health plan:
        - demonstrate it understands the number and types of providers necessary to supply covered medical benefits for current and potential enrollees;

- implement an acceptable process to establish appropriate goals for consumer access to and availability of the provider network, actively monitor and measures performance against those goals, and take actions necessary to improve performance; and
- actively monitor the performance of its network on an ongoing basis, compare network capacity to current and potential future enrollee needs, and share analysis findings with its QMC.

- URAC Provider Selection Criteria Standard P-NM 3 requires that an organization establish provider selection criteria addressing quality of care, quality of service, and the business needs of the organization. This standard is meant to validate that an organization is communicating clearly with providers about criteria and requirements that best meet the needs of a plan's enrollees. It intends for an accredited organization to promote appropriate access to health care such as:
  - ◊ responsiveness of the provider's office staff, cleanliness of the provider's office, and hours of operation;
  - ◊ the specific needs of a plan's consumers based on known population characteristics and/or special needs; and
  - ◊ primary care, specialty care, mental health and chemical dependency services, inpatient facilities, and ancillary providers either in network or out of network through referral.
- URAC Out of Network and Emergency Services Standard P-NM 4 requires, to the extent established by its covered benefits, that organizations implement written policies enabling consumer access to covered services not available among participating providers. It also enables access to emergency care both within and outside an organization's service area.
  - ◊ Organizations have an obligation to provide for consumers' medical care when necessary care is not available within the network or during a medical emergency within or outside an organization's service area.

HOW URAC STANDARDS ADDRESS PATIENT APPEAL RIGHTS |

Regarding the ability for patients to appeal health plan decisions:

- URAC Non-Certification Appeals Process Standard P-HUM 33 requires that an accredited organization implement and maintain a formal process for considering the appeal of non-certifications or denials of covered services. These policies must include timelines that comply with U.S. Department of Labor regulations for claims and appeals. They must also include timelines for appeals that cover non-urgent care and expedited time frames for urgent care needs.
    - ◊ This standard allows a health plan to track trends with respect to the utilization of out-of-network services – alerting them of the opportunity to address any in-network care gaps.
- As part of the appeal process, URAC Appeal Process Standard P-HUM 34 requires an organization to include and review all relevant information before rendering a decision on appeal about the necessity and appropriateness of care as requested by the patient and his/her provider. It provides:
    - ◊ an opportunity for the patient, provider, or facility rendering service to submit written comments, documents, records, and any other information related to a case;
    - ◊ inclusion of all information available at the time of the appeal in the review and decision; and
    - ◊ implementation of the clinician's treatment plan if the appeal overturns the initial non-certification.

CONCLUSION

URAC accreditation standards include rigorous consumer and patient safety protections for Qualified Health Plans to meet current regulatory requirements, demonstrate an ability to meet industry benchmarks for best practices, and provide appropriate access to health care services based on the needs of the populations and the communities they serve.

Specific accreditation requirements outlined in this issue brief are further buttressed by a network of supporting tools that include consumer surveys, ongoing analysis of consumer complaints, and easily-understood communications to enrollees. As QHP oversight evolves, state and federal regulators may choose to develop additional requirements for QHP provider networks. These requirements could then be incorporated into URAC's standards.

Recognizing the role of state governments in the continuing implementation of the ACA, URAC's standards addendum process also allows for the inclusion of program-specific requirements enacted by a state into a set of accreditation standards for its health plans. URAC continues to work with state and federal regulators in an effort to help safeguard consumer access to quality health care and the improvement of population health across the continuum of care.

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Founded in 1990, URAC is the independent leader in promoting healthcare quality through accreditation, certification and measurement. URAC is a nonprofit organization developing evidence-based measures and standards through inclusive engagement with a range of stakeholders committed to improving the quality of healthcare. Our portfolio of accreditation and certification programs span the healthcare industry, addressing healthcare management, healthcare operations, health plans, pharmacies, telehealth providers, physician practices, and more. URAC accreditation is a symbol of excellence for organizations to showcase their validated commitment to quality and accountability.