

Network Adequacy and Essential Community Providers

April 24, 2019

**Qualified Health Plan (QHP)
Issuer Conference**

This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.

The information provided in this presentation is not intended to take the place of the statutes, regulations, and formal policy guidance that it is based upon. This presentation summarizes current policy and operations as of the date it was shared. Links to certain source documents may have been provided for your reference. We encourage persons attending the presentation to refer to the applicable statutes, regulations, and other guidance for complete and current information.



[HTTPS://WWW.REGTAP.INFO](https://www.regtap.info)

Introduction

- This presentation will provide issuers with the Plan Year (PY) 2020 updates and reminders pertaining to the following topics:
 - Network Adequacy Policy
 - Essential Community Provider (ECP) and Network Adequacy Template for issuers operating in the Federally-facilitated Exchanges (FfEs), including FfEs where the state performs plan management functions
 - ECP tools for Qualified Health Plan (QHP) and Stand-alone Dental Plan (SADP) reviews

PY2020 Network Adequacy Review



[HTTPS://WWW.REGTAP.INFO](https://www.regtap.info)

PY2020 Network Adequacy Reviews

- CMS will continue to verify that provider networks are adequate using a three-pronged network adequacy review approach. Issuers will be classified into one of three prongs based on the state in which they are offering plans and accreditation status.
- CMS will continue to defer to states that are determined to have a sufficient network adequacy review process. This is defined as states with the authority to enforce standards that are at least equal to the “reasonable access standard” defined in 156.230 and means to assess issuer network adequacy. For PY2020, CMS has determined that all states have adequate network review authority.

PY2020 Network Breadth Pilot

- Network Breadth evaluates the breadth of provider networks and assigns a classification to display information on HealthCare.gov on the relative size of provider networks for plans in three (3) specialty* areas: PCP Adult, PCP Pediatric, and General Acute Care Hospital.
- Ratings are assigned based on “Provider Participation Rates” (PPR) - defined as the servicing providers for one (1) issuer/network/county/specialty combination divided by the total number of QHP servicing providers for that county and specialty. A “servicing provider” is any provider that is within the time and distance standards of the beneficiaries of a county - can either be in the county or a surrounding county.
- Thresholds are used to establish three (3) network ratings:
 - Basic: < 30%
 - Standard: $\geq 30\%$ to < 70%
 - Broad: $\geq 70\%$
 - Not Applicable: assigned to counties with only one (1) issuer and network

*NB for Adult Primary Care is based on the following specialties: 001 General Practice, 002 Family Medicine, and 003 Internal Medicine. For Pediatric Primary Care, it is based on specialty 101 Pediatrics, and for Hospitals it is based on 040 Hospitals.

PY2020 ECP/NA Template Overview

ECP Write-in Reminders and Rolling Draft ECP List

- For PY2020, the ECP write-in process will continue to be available to issuers for counting toward the issuer's satisfaction of the 20 percent ECP standard only for the issuer that:
 - Selects the provider from the HHS Available ECP Write-in List for PY2020; and
 - Writes in the provider on its ECP Write-in Worksheet by no later than August 21, 2019.
- Rolling Draft HHS ECP List
 - The Rolling Draft HHS ECP List reflects CCIIO's continually updated list of approved ECPs (updated monthly) that includes previously approved ECPs and newly available ECP write-ins for PY2020 (i.e., providers that have submitted an online ECP petition that has been approved by CCIIO).
 - Issuers may view this active list at any time via the online ECP petition site at: https://data.healthcare.gov/cciio/ecp_petition. Click the button beside question 6 to check for providers on the list.

Template ECP Population Logic Refresher

- When the issuer selects ECPs from the 'Select ECPs' tab, the template will auto-populate the 'Individual ECPs' and 'Facility ECPs' tabs based on the total number of medical and dental full-time equivalent staff (FTEs) available at the facility. If the selected provider is an inpatient hospital ECP, the template will auto-populate the 'Facility ECPs' tab and display hospital bed counts, rather than FTEs.
 - If the total number of FTEs for a selected provider is 0-1, then the ECP will populate as an 'Individual ECP.'
 - If the total number of FTEs or hospital beds for a selected provider is greater than 1, then the ECP will populate as a 'Facility ECP.'
- In both the 'Individual ECPs' and 'Facility ECPs' tabs:
 - The field 'Number of Medical FTEs' reflects the number of MDs, DOs, PAs, and NPs available at the facility that has contracted with the issuer.
 - The field 'Number of Dental FTEs' reflects the number of DMDs and DDSs available at the facility that has contracted with the issuer.
- In the 'Select ECPs' and 'Facility ECPs' tabs:
 - For PY2020, a new field 'Hospital Bed Count' displays within the 'Select ECPs' tab and 'Facility ECPs' tabs. This 'Hospital Bed Count' field reflects the number of staffed hospital beds available at the inpatient hospital that has contracted with the issuer.

Refresher on ECP Tools for PY 2020 QHP and SADP Reviews



[HTTPS://WWW.REGTAP.INFO](https://www.regtap.info)

Benefits of Using the ECP Review Tool

- Speeds up reviews
 - Example: Ability to review a large volume of submitted ECPs to identify service areas that do not meet the 20 percent ECP standard.
- Quickly and efficiently identifies concerns that may not easily be found through hands-on ECP review.
 - Example: Identifies any ECPs that fall outside of the issuer's service area.
- Allows for easier comparison of contracted ECPs across the ECP categories.
 - Example: Identifies ECP categories for which an issuer has not yet contracted to satisfy the category per county contract offering requirement.

Benefits of Using the ECP Review Tool (continued)

- Includes allowable ECP write-ins to count toward an issuer's satisfaction of the 20 percent ECP standard only for the issuer that writes in the ECP on its ECP write-in worksheet.
 - Available write-in providers are those that appear on the HHS Available ECP Write-in List for PY2020 by having submitted an ECP petition to HHS no later than the deadline for issuer submission of changes to the QHP application.
 - The “Available ECP Write-in List” appears as a tab within the tools so that ECPs on an issuer's ECP Write-in Worksheet can be imported into the tools and counted toward satisfaction of the 20 percent ECP standard

Live Demo

- Qualified Health Plan (medical) ECP Tool
- Stand-alone Dental Plan (SADP) ECP Tool

Where to Find Tools, User Guides, and References

- CMS has posted the Review Tools at the following location:
 - <https://www.qhpcertification.cms.gov/s/Review%20Tools>
- The ECP/NA Template and Instructions can be found at the following location:
 - <https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>

Deficiencies and Justifications

- As in previous years, if an issuer's application does not satisfy the ECP standard, the issuer would be required to include as part of its application for QHP certification a satisfactory narrative justification describing how the issuer's provider networks, as presently constituted,
 - Provide an adequate level of service for low-income and medically underserved individuals
 - How the issuer plans to increase ECP participation in its provider networks in future years
- At a minimum, a narrative justification would include:
 - Number of contracts offered to ECPs for PY2020
 - Number of additional contracts an issuer expects to offer and the timeframe
 - Names of the specific ECPs to which the issuer has offered contracts that are still pending
 - Contingency plans for how the issuer's provider network, as currently designed, would provide adequate care to enrollees who might otherwise be cared for by relevant ECP types that are missing from the issuer's provider network
- Additional justification examples would include:
 - A medical facility that appears on the Final PY2020 ECP List but has recently closed or no longer provides dental services (the latter being an example of a justification for an SADP issuer)
 - A medical facility that appears on the Final PY2020 ECP List but has indicated that it no longer contracts with any Marketplace plans

Stand-alone Dental Plans (SADPs): Qualified Health Plan (QHP) Certification

April 24, 2019

**Qualified Health Plan (QHP)
Issuer Conference**



[HTTPS://WWW.REGTAP.INFO](https://www.regtap.info)

Agenda

- Overview of Stand-alone Dental Plans
- Certification Timeline & Requirements
- Draft 2020 Letter to Issuers
 - Maximum Out-of-Pocket (MOOP)
 - SADP Actuarial Value (AV) Requirements
- SADP Key Topics
 - Age Limitation
 - Explanation and Exclusions Fields
 - No Waiting Period
- Application Modules and Templates
 - Benefit and Service Area – Plans & Benefits Template
 - Rating Templates
- Question & Answer (Q&A) Session

Overview of SADPs

- SADPs are treated uniquely in the Patient Protection and Affordable Care Act.
 - Various statutory and regulatory standards apply differently to Qualified Health Plans (QHP) SADPs than to other QHPs.
- All SADPs in the Exchange must cover pediatric dental Essential Health Benefits (EHBs).
- Other QHPs must offer all EHBs but can “carve-out” the pediatric dental EHB in an Exchange that also offers an Exchange-certified SADP.

Overview of SADPs (continued)

- SADP issuers can announce their intent to apply for certification – this helps QHP issuers know whether there will be an SADP in the Exchange and design their products accordingly.
- Outside of the Exchange, issuers of medical plans subject to the EHB requirements may offer to an individual a plan that excludes pediatric dental coverage as an EHB only if:
 - “reasonably assured” that the individual has already purchased an Exchange-certified SADP.

QHP Certification Requirements for SADPs

Table 4.1: Standards and Tools Applicable to Stand-alone Dental Plans

Standards and Tools that Do Apply (*denotes modified standard)	
Essential Health Benefits*	Actuarial Value*
Annual Limits on Cost Sharing*	Rates submission*
Essential Community Providers/Network Adequacy*	SADP Essential Community Provider (ECP) Tool*
Non-discrimination	Service Area
Acceptance of Third Party Premium and Cost-sharing Payments	Data Integrity Tool
Transparency in Coverage Reporting	Machine Readable* (SADPs must comply with provider directory standards but not drug formulary standards)

QHP Certification Requirements Not Applicable for SADPs

Table 4.2: Standards and Tools Not Applicable to SADPs

Standards and Tools that Do Not Apply	
Accreditation	Patient Safety
Quality Reporting (Quality Rating System and QHP Enrollee Experience Survey) and Quality Improvement Strategy	Prescription Drugs
Cost-sharing Reductions	Out-of-Pocket Cost Comparison Tool

Draft 2020 Letter to Issuers – SADPs

- SADP Annual Limitation on Cost Sharing
 - In the Draft 2020 Letter to Issuers in the FFEs, we noted that, because the percentage increase in the Consumer Price Index (CPI) for dental services would raise the dental annual limitation on cost sharing (MOOP) less than \$25, for Plan Year (PY) 2020 the MOOP will remain \$350 for one child and \$700 for two or more children.
 - The per-child MOOP limit of \$350 applies to each child individually.
 - Once any enrolled child reaches \$350 in out-of-pocket spending, the plan may not charge additional out-of-pocket costs for EHB for that child, regardless of whether the plan has one or more enrolled children.
 - The limit of \$700 applies to plans with two or more enrolled children. A family may not be charged additional out-of-pocket costs for EHB once all enrolled children collectively have reached \$700 in out-of-pocket costs.
 - Total cost sharing for EHBs should not be greater than the MOOP.

Draft 2020 Letter to Issuers – SADPs (continued)

- SADP Actuarial Value Requirements
 - For PY2020, SADP issuers may offer the pediatric dental EHB at any AV and are not required to enter the high or low level of coverage into the template. If the level of coverage is provided, the SADP's AV must be within the de minimis range for the high or low level.
 - The AV for the pediatric dental EHB, however, must be entered on the AV supporting document and must be certified by an actuary who is a member of the American Academy of Actuaries.

SADP Key Topics

- Age Limitation
 - Pursuant to the provision of EHB at 45 CFR 156.115(a)(6), all SADPs must cover pediatric dental benefits for individuals until at least the end of the month in which the enrollee turns 19 years of age.
 - However, states can impose requirements to provide pediatric services to individuals up to a higher age but not lower.
- Explanation and Exclusion Fields
 - The Explanation and Exclusion fields on the plans and benefits template can be used to provide details on a benefit.
 - Issuers are advised to ensure that templates are internally consistent. Information in the Explanation and Exclusions fields must not contradict information entered in other parts of the template associated with any EHB.
 - Benefits cannot discriminate on the basis of color, race, national origin, disability, age, sex, gender or sexual orientation.

SADP Key Topics (continued)

- Prohibition of Waiting Periods
 - Waiting periods are not allowed for any EHBs, including pediatric orthodontia EHB.
 - Imposing a waiting period on an EHB could mean the issuer is not offering coverage that provides EHB as required by 45 CFR 156.115.
 - <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Waiting-period-FAQ-05262016-Final-.pdf>

Application Modules and Templates

- Issuer Module
 - Program Attestations
 - Licensure and Good Standing (optional sections)
 - ECP/Network Adequacy
 - Accreditation – Not applicable (N/A) for SADPs
- Benefit and Service Area Module
 - Service Area
 - Plans & Benefits (unique to SADPs)
 - Network ID
 - Prescription Drug – N/A for SADPs
- Rating Module
 - Rating Table template
 - Business Rules template
- Rate Review Module
 - Unified Rate Review – N/A for SADPs
 - EHB Apportionment will be collected as part of the Plans & Benefits template for SADPs

Benefit and Service Area – Plans & Benefits Template

- The Plans & Benefits template has a Dental Macro that can be activated by selecting “Yes” in the Dental Only Plan field
- The template will grey out all benefits except:
 - Basic Dental Care–Adult
 - Basic Dental Care–Child
 - Dental Check-Up for Children
 - Major Dental Care–Adult
 - Major Dental Care–Child
 - Orthodontia–Adult
 - Orthodontia–Child
 - Accidental Dental
 - Routine Dental Services (Adult)

Benefit and Service Area – Plans & Benefits Template (continued)

- AV for SADPs
 - Issuers are not required to enter the AV level of coverage into the template. While this field is optional, if an issuer provides the level of coverage, the SADP's AV must fall within the previous requirements of:
 - High: Actuarial Value of 85% +/- 2%
 - Low: Actuarial Value of 70% +/- 2%
- There is no actuarial value calculation in the template for SADPs.
- The AV for the pediatric dental benefit should be calculated by an actuary and the AV listed on the AV supporting document and certified by an actuary.
- There are no Cost Sharing Reduction (CSR) plan variations for SADPs; therefore, such data will be not be auto-populated.

Benefit and Service Area – Plans & Benefits Template (continued)

- Two (2) data fields on Benefit Package tab are designated for only SADPs:
 - EHB Apportionment
 - The percentage of EHB Apportionment for Pediatric Dental
 - While EHB categories are standard, the issuer can add more granularity via the EHB justification allocation, although it is not required.
 - Guaranteed vs. Estimated Rate
 - Identify whether plan offers guaranteed or estimated rates
- Summaries of Benefits and Coverage are not applicable for SADPs.

Rating Templates

- Individual Exchange SADP issuers must complete the rating templates and must indicate in the Plans and Benefits Template if those rates are estimated or guaranteed for the Individual Exchange.
- If guaranteed rates are selected, the issuer must charge consumers the exact rates entered in the Rates Table Template.
- If estimated rates are selected, the issuer must make adjustments to the rates charged to consumers beyond what is entered in the Rates Table Template.
- Consumers can identify whether an SADP rate is “Estimated” or “Guaranteed” when shopping for plans on HealthCare.gov.

Questions

