Network Adequacy, Essential Community Providers, Stand-Alone Dental Plans

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Qualified Health Plan (QHP) Issuer Conference

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Introduction

- This presentation will provide issuers with the Plan Year (PY) 2021 updates and reminders pertaining to the following topics:
  - Review of Network Adequacy Policy
  - Overview of 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
  - Benefits of using the ECP tools for Qualified Health Plan (QHP) and Stand-alone Dental Plan (SADP) reviews
  - SADP policy reminders and updates

PY2021
Network Adequacy Review

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PY2021 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 PY2021, CMS has determined that all states have adequate network review authority.

PY2021 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: >= 30% to < 70%
  - Broad: >= 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.

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PY2021
ECP/NA Template Overview

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2021 ECP/Network Adequacy Template – version 10.1

2021 ECP/Network Adequacy Template v10.1

User Control & Details for Template

Issuer Information

Issuer ID:*	
Source System:*	
State:*	
Is this an Alternate ECP Standard Issuer?*	No

Actions

1. Create New Provider Tab

Please enter all Issuer Information *above before creating a new tab.*

A. New Individual Provider (MD/DO) Tab
Keyboard users: press *Ctrl + Shift + I*

[Create Individual (MD/DO) Tab]

B. New Facility, Pharmacy, Non-MD/DO Tab
Keyboard users: press *Ctrl + Shift + F*

[Create Facility, Pharmacy, Non-MD/DO Tab]

2. Import Network IDs

Press the Import Network IDs button or Ctrl + Shift + N to import a list from the Network ID template.
Warning : this step is required in order to complete

[Import Network IDs]

3. Validate Data

Validate information entered into all tabs. Warning: Depending on data size, validation may take several minutes.

[Validate]

4. Create Supporting Documents

Perform data validation & export data to XML fil

[Create Documents]

5. Delete an Exisiting Tab?

Refer to Column P on this tab if you would like to delete an existing tab.

Notes & Instructions

1. Enter all Issuer Information *, then create a new tab using the buttons below to enter data*

2. Ensure automatic calculation is turned on. Formulas -> Calculation Options -> Automatic

3. Data can be entered manually or Copy & Pasted into each tab

*4. All fields with an asterisk (*) are required*

5. Validate data (press the "Validate" button or Ctrl + Shift + V) after entering in all information

Exporting Data:

1. Data must pass all validation checks before being exported. Any invalid entries will be displayed in the 'Errors' tab and must be

2. Press "Create Documents" button or Ctrl + Shift + E to export data from all provider tabs.

3. When prompted, select the folder in which you wish to save the files.

4. All files will be saved as XML files.

Warning : Files larger than 50mb cannot be uploaded to HIOS/SERFF. Please ensure that each exported XML file is less than 50mb. On average, tabs with less than 100,000 records

Validation Status
Incomplete

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ECP Write-in Reminders and Rolling Draft ECP List

- For PY2021, 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 PY2021; and
  - Writes in the provider on its ECP Write-in Worksheet by no later than August 19, 2020.
- Rolling Draft HHS ECP List
  - The Rolling Draft HHS ECP List reflects CCIIO's continually updated list of approved ECPs that includes previously approved ECPs and newly available ECP write-ins for PY2021 (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.
  - If the total number of available FTEs for a selected provider is 0-1, then the ECP will populate as an ‘Individual ECP.’
  - If the total number of available FTEs or hospital beds for a selected provider is greater than 1, then the ECP will populate as a ‘Facility ECP.’

Template ECP Population Logic Refresher (continued)

- In both the ‘Individual ECPs’ and ‘Facility ECPs’ tabs:
  - The issuer must complete the ‘Number of Medical FTEs’ field to reflect the number of MDs, DOs, PAs, and NPs available to provide health care services at the facility through the facility’s contract with the issuer.
    - The number of FTEs entered by the issuer in the ‘Individual ECPs’ tab must not be greater than the number of available FTEs reported by the respective provider as reflected in the ‘Select ECPs’ tab.
  - The issuer must complete the ‘Number of Dental FTEs’ field to reflect the number of DMDs and DDSs available to provide health care services at the facility through the facility’s contract with the issuer.
    - The number of FTEs entered by the issuer in the ‘Facility ECPs’ tab must not be greater than the number of available FTEs reported by the respective provider as reflected in the ‘Select ECPs’ tab.
- In the ‘Facility ECPs’ tab:
  - The issuer must complete the ‘Hospital Bed Count’ field to reflect the number of staffed hospital beds available at the inpatient hospital through the facility’s contract with the issuer.
    - The number of beds entered by the issuer in the ‘Facility ECPs’ tab must not be greater than the number of available beds reported by the respective provider as reflected in the ‘Select ECPs’ tab.

Refresher on ECP Tools for PY 2021 QHP and SADP Reviews

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.

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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 PY2021 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

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 PY2021
  - 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 appearing on the Final PY2021 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 appearing on the Final PY2021 ECP List but has indicated that it no longer contracts with any Marketplace plans

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

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SADPs: QHP Certification

Agenda

- Overview of Stand-alone Dental Plans
- Certification Timeline & Requirements
- Draft 2021 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)

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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 2021 Letter to Issuers – SADPs

- SADP Annual Limitation on Cost Sharing
  - In the Draft 2021 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) 2021 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 2021 Letter to Issuers – SADPs (continued)

- SADP Actuarial Value Requirements
  - SADP issuers may offer the pediatric dental EHB at any actuarial value (AV).
  - SADP issuers must certify the AV of each SADP's coverage of pediatric dental EHB.

SADP Supporting Documentation

- All SADP issuers must submit the following two supporting documents:
  - "Stand-Alone Dental Plan Actuarial Value" form, certifying the value of each SADP's coverage of pediatric dental EHB.
  - "Stand-Alone Dental Plan Description of EHB Allocation" form, certifying the monthly premium allocable to pediatric dental EHB of a child-only plan.
- Both supporting documents must be certified by a member of the American Academy of Actuaries using generally accepted principles and methods.

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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)

- While SADPs are required to complete the Level of Coverage field within the Plans and Benefits Template (PBT), entering the AV within the PBT is optional. If an AV is provided on the PBT, it must fall within the previous AV ranges of high (85 percent) or low (70 percent), as described in 45 CFR 156.140.
- There is no actuarial value calculation in the template for SADPs.
- 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.

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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 can 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?

- To Submit or Withdraw Questions by Phone:
  - *If you are listening through your computer speakers and want to submit a question by phone, dial* 1-866-391-5945 and enter your unique six-digit PIN, then dial *"star(*) pound(#)" on your phone's keypad.*
  - *If you are already dialed in by phone and want to submit a question, then dial "star(*) pound(#)" on your phone's keypad.*
  - *If you would like to withdraw a question and you are dialed in by phone, then dial "star(*) pound(#)" on your phone's keypad.*
- To submit questions by webinar:
  - *Type your question in the text box under the "Q&A" tab and click "Send."*

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