

Session Two – Provider Contracts and Provider Networks for Commercial and Medicaid Plans

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Session Overview

- Introduction and Brief Review of Key Terms
- Role of Insurance Commissioner vs. Health Care Authority
- Types of Health Issuers – and the products they sell
- Medicaid Managed Care Plans – and “Churn”
- In-network vs. out-of-network status
- Provider Networks and Network Adequacy
- Essential Community Providers – how they are part of a QHP’s network
- Intro to the Provider Contract – key provisions
- Intro to the Compensation Exhibit
- Questions

Key Terms

- “Essential Community Provider” -are providers that serve predominantly low-income, medically underserved populations and in Washington State – The Insurance Commissioner defines and Essential Community Provider under WAC 284-43 -221 see: <http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-221> -
- “Health Benefit Plan” – The health coverage product defined by the:
 - covered services (Essential Health Benefits plus any additional benefits added by the issuer)
 - the limitations/exclusions,
 - the cost sharing (deductible, copays & coinsurance); and
 - network
- “Issuer” – the type of health carrier that provides the health care coverage- In Washington there are 3 different types of issuers:
 - Health Care Service Contractor - such as Premera BlueCross, Regence BlueShield
 - Health Maintenance Organization (HMO) such as Group Health Cooperative
 - Disability Insurance Company – such as United Healthcare and Aetna

Key Terms

- “Network” means the group of participating providers and facilities providing health care services to a particular health plan or line of business (individual, small, or large group). A health plan network for issuers offering more than one health plan may be smaller in number than the total number of participating providers and facilities for all plans offered by the carrier
- “Non-network Provider” – A provider or facility that is not under contract and may bill the Commercial patient for all charges not paid by issuer (balance billing) (Apple Health has exceptions around hospitalization)
- “Participating Provider” – A provider or facility that has a signed contract with an issuer and agrees to look solely to the issuer for payment of covered services (hold harmless provision) – may not balance bill the patient even if issuer does not pay the claim

Key Terms

- “Office of Insurance Commissioner (OIC)” – the primary regulator of insurance – enforces both state and federal law including the ACA.
- “Qualified Health Plan or QHP” – an individual or small group health benefit plan that is purchased through the Health Benefit Exchange – Washington Healthplanfinder. QHPs are not issued to Medicaid beneficiaries
- “Service Area” the geographic area or areas where a specific product is issued, accepts members or enrollees, and covers provided services. A service area must be defined by the county or counties unless the commissioner permits limitation of a service area by zip code due to geographic barriers within a service area, or other conditions that make offering coverage throughout an entire county unreasonable.

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- Do you know the role of the Health Care Authority vs. the Office of the Insurance Commissioner in the contracting process?

Role of the OIC vs. Health Care Authority

- The OIC reviews and approves the health benefit plan contracts; the rates; the provider contracts, and provider networks for all individual and small group products sold on the Exchange (QHPs) and outside market.
- The Health Benefit Exchange Board cannot certify a plan as QHP unless it has been approved by the OIC
- The Health Care Authority (HCA) contracts with the managed care Medicaid plans that offer “Apple Health” products.
- The HCA reviews the Apple Health networks for adequacy **but the OIC approves the provider contracts**

Regulation of Various Types of “Insurance” Programs & Networks

“Insurance” Program	Description	Who Regulates or Controls?	Who regulates the Network?
Commercial Insurance – Inside the Exchange	<p>The health benefit plans known as Qualified Health Plans (QHPs) and Qualified Dental Plans (QDPs) available for individuals and small groups (<50) through the Health Benefit Exchange (HBE.) These are fully insured products that must comply with the state insurance code and the Affordable Care Act (ACA.)</p> <p>QHPs <u>must</u> contract with at least some of each type of “willing” Essential Community Providers and cover Essential Health Benefits</p> <p>Coverage is for enrollees who do not qualify for Medicaid – but may be eligible for tax credits and cost sharing reductions if under 400% FPL</p>	<p>1) The OIC must approve the health benefit plans and networks and regulates the issuers</p> <p>2) The Health Benefit Exchange Certifies the QHPs and QDPs for Washington</p>	<p>1) OIC reviews network for adequacy</p> <p>2) Health Benefit Exchange Certifies Network As part of Qualified Health Plan Certification</p> <p>3) Federal Government provides authority under federal law</p>
Commercial Insurance – Outside of the Exchange	<p>All fully insured individual, small group and large group insurance products sold outside of the HBE.</p> <p>Individual and small group non-grandfathered plans must cover Essential Health Benefits – but do not have to contract with Essential Community Providers</p>	<p>1) The OIC enforces state and federal law</p> <p>2) Federal Government establishes ACA requirements through rule making but delegates enforcement to OIC</p>	<p>1) The OIC reviews the network for Adequacy under state law</p> <p>2) Federal Government provides authority under federal law</p>
Managed Care Medicaid “Apple Health”	<p>Program for low income for individuals – including children at or below 138% FPL</p>	<p>1) Health Care Authority – provides primary oversight</p> <p>2) OIC licenses the companies and approves provider contracts</p>	<p>1) The HCA</p>

Types of Issuers- and the products they sell

- It is important to understand the type of issuer because they are governed by different laws and rules – and there are 3 main “types”
- Health Care Service Contractors (HCSCs)– These types of issuers receive a Certificate of Registration from the OIC and are “exempt from the laws of insurance” when they provide “pre-paid health care services” through networks of participating providers
 - The distinction is not quite as important as in previous years but it used to be a far less burdensome regulatory scheme
 - Most of the health issuers in the individual and small group market are HCSCs
 - Examples are Premiera Blue Cross, Regence BlueShield of Washington; Lifewise of Washington to name a few

Types of Issuers- and the products they sell

- Health Maintenance Organizations – or HMOs – must provide all of their services (except for emergency services) through networks of participating providers and unlike the HCSCs they must provide the full range of health care services (hospital, physician services, lab and X-ray etc.) and may not issue stand alone products such as dental or vision only.
 - Examples in Washington are: Molina; Group Health Cooperative and Coordinated Care
 - Some HMOs are called “staff model” HMOs and actually run their own hospitals and employ the medical staff –or combine both staff provided services and network providers- Group Health is a “staff model HMO”

Types of Issuers- and the products they sell

- The third type of “issuer” are disability insurance companies – or ‘true insurers.’ These companies are authorized to sell many different types of insurance products – with health insurance being just one type of product
- Other types of products from disability insurers include disability income; accidental death and dismemberment; specified disease such as cancer only indemnity products
- Disability Insurers **are not** required to provide their health insurance products utilizing “network providers” – but virtually all of them do
- Disability Insurers are far more likely to provide “administrative only services” and “rent” their network to self-insured employer groups
- Examples of disability insurers are UnitedHealth Care; Aetna Life; Health Net of Oregon

Types of Issuers- and the products they sell

- Managed Care Medicaid (Apple Health) – is a source of health care coverage not a type of issuer
- Managed Care Medicaid products can be offered by any one of the 3 issuer types – HCSC; HMO or disability insurance company
- The OIC licenses the issuers; monitors the issuer's solvency and approves the provider contracts for Managed Care Medicaid plans as part of its overall regulatory functions - but does not review the contracts or handle complaints
- The HCA – procures the plans – negotiates the rates, establishes the terms and conditions of the coverage and assures network adequacy for the Medicaid plans
- LHJs – will need to be familiar with these differences because of the “churn” factor

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- Do you know what “churn” is?

Medicaid Managed Care Plans – and “Churn”

- Up until 2014 – most Medicaid Managed Care plans such as Molina, Community Health Plan of Washington and Coordinated Care were not in the commercial insurance market
- Most of the issuers in the commercial insurance market did not participate in Medicaid Managed Care programs – with Group Health Cooperative up until July of 2012 being one of the few exceptions
- Beginning in 2014 – many of the Medicaid Managed Care plans decided to enter the commercial market to offer QHPs
- These plans wanted to capture the market share for “Medicaid churn” – individuals and families who transitioned back and forth between the commercial market and Medicaid due to changes in eligibility and financial status

Medicaid Managed Care Plans – and “Churn”

- The “state” wanted the Medicaid Managed care plans in the commercial market so patients could maintain their provider/patient relationships to help with continuity of care
- This entry into the commercial market was anything but smooth for the Medicaid Managed care plans and the OIC
- The Medicaid only issuers were not used to the very different regulatory compliance requirements in the commercial market and struggled to get their products and networks approved
- The OIC spent a great deal of time trying to educate the Medicaid issuers about the requirements for individual and small group products
- LHJs may encounter problems because of confusion about the dual oversight functions of the HCA and OIC – and it is important to understand the differences so LHJ staff know where to go for help

Medicaid Managed Care Plans – and “Churn”

- LHJs may experience administrative problems when dealing with patients that switch from the Medicaid coverage to the commercial coverage – especially if they switch to a different issuer
- Adult family members may have the commercial Qualified Health Plan – and the children may be enrolled in Apple Health (Medicaid)
- Patients may not understand the difference or realize that they need to provide up to date coverage information every time they obtain care
- Medicaid Managed care plans just entering the commercial market may not have the infrastructure to deal “directly” with consumer problems

In-network and out-of-network benefits

- Many health benefit plans including QHPs have both in-network and out-of-network benefits
- In-network benefits have lower cost sharing amounts and cost sharing amounts apply to the out-of-pocket maximums
- Network providers agree to accept the issuer's negotiated allowed amount
- Out-of-network providers can bill the patient for any amounts not covered by the health benefit plan
- Even if you are not a network provider you should obtain insurance information and bill the issuer as you may receive some level of payment

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- Have you billed as an out-of-network provider and received payment from an issuer?

Provider Networks and Network Adequacy

- Most issuers either must provide health services through networks of participating providers (HCSCs & HMOs) or choose to use networks (disability insurers)
- In general terms – a network of participating providers must be sufficient in number and choice of providers to deliver the services promised under the health benefit plan –
- The Affordable Care Act (ACA), the state insurance laws and the rules governing the Medicaid Managed Care Plans require that the networks be adequate – and provide for consumer protections when they are not
- In Washington – the OIC reviews the issuer's commercial networks for adequacy and the HCA reviews the Medicaid Managed Care Plan networks

Provider Networks and Network Adequacy

- Issuers may have just one network but most have several – Premiera has about 10
- The difference between networks is based on several factors:
 - The amount of provider compensation/discount
 - The health insurance product it supports (Medicaid vs. QHP vs. Commercial)
 - How “open” the network is and whether there are financial incentives for quality and health outcomes
- The provider may be in many different networks – and unfortunately may not always know!
- Each issuer “names” its network and should clearly indicate the name on the patient’s ID card as well as in their provider directory
- The typical patient doesn’t understand their network – and may receive services from “out-of-network” providers

Network Adequacy- Federal Standard

- The ACA establishes standards for Network Adequacy for QHPs

§156.230 Network adequacy standards.

(a) *General requirement.* A QHP issuer must ensure that the provider network of each of its QHPs, as available to all enrollees, meets the following standards—

- (1) Includes essential community providers in accordance with §156.235;
- (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and,
- (3) Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act.

(b) *Access to provider directory.* A QHP issuer must make its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from the Exchange and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients.

Network Adequacy- State Standard for Commercial Market

- The OIC updated its rules for 2015 –

WAC 284-43-200 – Network Access General Standards:

“An issuer must maintain each provider network for each health plan in a manner that is sufficient in numbers and types of providers and facilities to assure that, to the extent feasible based on the number and type of providers and facilities in the service area, all health plan services provided to enrollees will be accessible in a timely manner appropriate for the enrollee's condition. An issuer must demonstrate that for each health plan's defined service area, a comprehensive range of primary, specialty, institutional, and ancillary services are readily available without unreasonable delay to all enrollees and that emergency services are accessible twenty-four hours per day, seven days per week without unreasonable delay.”

Network Adequacy standards for Apple Health

The network standards in the current 2014 Apple Health contract template*

6.1 Network Capacity

- 6.1.1 The Contractor shall maintain and monitor an appropriate provider network, supported by written agreements, sufficient to serve enrollees enrolled under this Contract (42 C.F.R. § 438.206(b)(1)).
- 6.1.2 The Contractor shall provide contracted services through non-participating providers, at a cost to the enrollee that is no greater than if the contracted services were provided by participating providers, if its network of participating providers is insufficient to meet the medical needs of enrollees in a manner consistent with this Contract. The Contractor shall adequately and timely cover these services out of network for as long as the Contractor's network is inadequate to provide them (42 C.F.R. § 438.206(b)(4)). This provision shall not be construed to require the Contractor to cover such services without authorization except as required for emergency services

* Complete contract available at:

http://www.hca.wa.gov/medicaid/healthyoptions/Documents/2014_apple_health_contract_6_2014.pdf

Network Adequacy – Narrow Networks – so what's the problem?

- As issuers attempt to reduce the health care cost curve – they are focusing on provider reimbursement rates
- Many issuers have developed limited or narrow networks
- Issuers often call these by marketing names such as “High Value” or “Efficient” networks
- These limited networks are controversial and subject to litigation – Seattle Children’s Hospital filed an administrative appeal because they were excluded from certain health issuer’s networks
- Issuers and the OIC believe narrow networks are OK as long as the consumer is informed through network transparency
- OIC – updated requirements for provider directories to improve transparency

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- Do you know what an ACO or integrated network is?

Network Adequacy – Integrated or “ACO” Networks

- One of the more recent developments in the market is the introduction of “integrated” networks – that are sometimes called Accountable Care Organization (ACO) Networks
- Major hospital and provider groups are coming together to form these networks and their compensation is based on improving health outcomes
- Virtually all services need to be obtained from the ACO network except for emergency services or referrals outside of the network for unique and highly specialized care such as transplants, trauma care
- Some of the “ACO” networks include Providence/Swedish; UW Medicine; Everett Clinic; EvergreenHealth to name a few
- These networks most likely will be offered by QHPs in 2015
- QHPs based on “integrated delivery systems” are not required to contract with Essential Community Providers – as long as the services are available in the network

Network Adequacy Rule Making for 2015 – Phase 1

- Prior to this spring – the OIC's network adequacy rules were based on the National Association of Insurance Commissioner's (NAIC) model rules first adopted in 1996
- HHS adopted a standard for the 2014 plan year that any state that used the NAIC model would be deemed in compliance with network adequacy review standards
- The rules – found in WAC 284-43-200 through 262 were fairly general without specific measures
- After the 2014 plan year review process – the OIC determined that it needed to update the rules for 2015 plan year
- The new rule making was controversial and although adopted in late April – many stakeholders were opposed to the adoption

Network Adequacy Rule Making for 2015 – Phase 1

- The OIC published the new rule as well as their Concise Explanatory Statement (CES) on their website at:
<http://www.insurance.wa.gov/laws-rules/legislation-rules/recently-adopted-rules/2013-25/index.html>
- The CES summarizes all of the stakeholder comments during written and public testimony and provides the Commissioner's response – it is over 95 pages long
- The OIC is beginning rule making for Phase 2 and 2016 networks and their notice of rulemaking is here:
<http://www.insurance.wa.gov/laws-rules/legislation-rules/proposed-rules/2014-08/>

Network Adequacy Rule Making

- The National Association of Insurance Commissioners and the HHS/CMS is also developing network adequacy standards for 2016
- The NAIC drafts and comments are very informative and are available at:
http://naic.org/committees_b_rftf_namr_sg.htm

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- Are you an essential community provider?

Essential Community Providers in QHP networks

- Essential Community Providers serve predominantly the low income and medically underserved and are required to be included in the QHP issuer's networks
- The OIC – set minimum standards for some for adequacy for some but not all types of ECPs in their network adequacy rule – WAC 284-43-222 at:
<http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-222>
- Of particular note are the adequacy standards for ECPs:
 - “(1) An issuer must include essential community providers in its provider network for qualified health plans and qualified stand-alone dental plans in compliance with this section and as defined in WAC [284-43-221](#).
 - (2) An issuer must include a sufficient number and type of essential community providers in its provider network to provide reasonable access to the medically underserved or low-income in the service area, unless the issuer can provide substantial evidence of good faith efforts on its part to contract with the providers or facilities in the service area. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider”
- Some of the minimum standards may not be sufficient however

Essential Community Provider Types

Major ECP Category	ECP Provider Types
Federally Qualified Health Centers (FQHC)	FQHC and FQHC “Look-Alike Clinics, Outpatient health programs/facilities operated by Indian tribes, tribal organizations, programs operated by Urban Indian Organizations
Ryan White Providers	Ryan White HIV/AIDS Program Providers
Family Planning Provider	Title X Family Planning Clinics and Title X “Look-Alike” Family Planning Clinics
Indian Health Providers	Indian Health Service (HIS) providers, Indian tribes, Tribal organizations and urban Indian Organizations
Hospitals	Disproportionate Share Hospital (DSH) and DSH-eligible Hospitals, Children’s Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers and Critical Access Hospitals
Other ECP Providers	STD Clinics; TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, and other entities that serve predominantly low-income, medically underserved individuals

Provider Contracts – the Basics

- Issuers are required to file their provider contract templates and compensation exhibits with the OIC for approval – 30 days prior to use
- The authority to require filings is under RCW 48.43.730 see:
<http://apps.leg.wa.gov/rcw/default.aspx?cite=48.43.730#>
- The OIC reviews the provider contract for compliance with a variety of state and federal rules – and uses a “analyst checklist” as a guide that is available on the OIC website at:
 - <http://www.insurance.wa.gov/for-insurers/filing-instructions/file-health-care-disability/documents/Analyst-Checklist-Provider-Agreement.pdf>

Provider Contracts – the Basics

- The OIC reviews and approves provider contracts for commercial plans and the Managed Care Medicaid plans
- If the issuer wants to make a material change to the previously approved provider contract template – it must be filed with the OIC for approval
- The compensation exhibits are also filed with the OIC – but are withheld from public disclosure

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- Have you ever negotiated a payer contract?

Key Provisions in a Provider Contract – what you should expect to see

The 3rd training session will go into quite a bit of detail but for today – here is a list of some of the common terms and requirements in a provider contract:

- The parties to the contract – the name of the issuer or issuers and the provider –
- The effective date -
- The term date (if applicable) – some are “evergreen” renewing until either party sends notice of termination without cause
- Renewal and termination provisions – including for termination with or without cause
- Notice requirements including timelines – some are very specific

Key Provisions in a Provider Contract – what you should expect to see

- The “Hold Harmless Provision” that prevents a participating provider from billing a patient for covered services (except copays, deductible and coinsurance amounts) even if the issuer does not pay the claim
- Continuity of Care provisions in the event of contract termination
- Provider Grievance Procedure and dispute resolution – issuer may not require binding arbitration in lieu of judicial remedies
- Overpayment/Underpayment Recovery provisions (with time limits)
- Mutual audit rights
- Standards for patient – care – issuer may not discourage the discussion of treatment options

Key Provisions in a Provider Contract – what you should expect to see

- Minimum notice of 60 days' for changes in compensation
- Requirement to comply with Provider Manual (policies and procedures) – but manual may not be incorporated by reference into the contract – and any changes in procedures that impact compensation must be in the contract
- Provider contract may not contain provisions that alter the patient's benefit contract
- The contract most likely will have a non-disclosure clause for compensation amounts

The Compensation Agreement

- The provider contract will contain the compensation schedule and it is usually attached as a separate exhibit
- The compensation agreement is filed with the OIC
- The OIC does not regulate provider reimbursement rates, but will review the general terms and conditions to assure that the underlying network and health benefit plan does not discriminate based on health status
- Unlike the underlying provider contract template which is subject to public disclosure – the compensation agreement is exempt from public inspection
- The compensation schedule may be as simple as a discount fee for service or based on a conversion factor applied to Medicare or Medicaid rates

The Compensation Agreement

- LHJs should expect to receive a copy of the provider contract and compensation schedule when negotiation with an issuer
- Make sure you understand the compensation methodology – as well as understand if there are automatic updates or changes that could impact reimbursement rates

Questions?

- Questions may also be sent to Carri Comer at carri.comer@doh.wa.gov or (360) 236-4004

Carri Comer

Washington State Department of Health

Strategic Operation Lead for Health Systems Transformation and Innovation

Where to go for Help

- Issuer Provider Relations

Most issuers will assign a provider representative for you to contact. You can also call the health issuer's customer service unit and they frequently have dedicated lines for providers

- Office of Insurance Commissioner

The OIC's Consumer Advocacy hotline: 1-800-562-6900 or file an "on-line complaint" at:

<http://www.insurance.wa.gov/complaints-and-fraud/file-a-complaint/>

Even if the OIC does not have jurisdiction – their consumer advocates can often provide helpful advice

- Health Care Authority (Medicaid / Apple Health)

1-800-562-3022

<http://www.hca.wa.gov/medicaid/provider/Pages/index.aspx>

Helpful links

- Insurance Commissioner's Web Site:
www.insurance.wa.gov
- Health Plan Finder – Washington's Health Benefit Exchange
<http://www.wahbexchange.org/>
- Topical Fact Sheets dealing with ACA issues from Federal Government
<http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/index.html>
- Glossary of Terms under the ACA”
<https://www.healthcare.gov/glossary/>
- HRSA Guidelines for Women's Preventive Services Guidelines:
<http://www.hrsa.gov/womensguidelines/>

Helpful Links

- National Association of Insurance Commissioner's Work Group on Network Model Act:

http://www.naic.org/committees_b_rftf_namr_sg.htm

- Georgetown University Center for Health Insurance Reforms

<http://chir.georgetown.edu/>