Provider Network Adequacy Q&A

- Are carriers required to file the provider availability standards referenced in **11 NCAC 20 .0301?**
  - Yes.
- If yes, are these filed in the initial product filing and are changes filed?
  - Provider availability standards are generally applicable to the HMO and PPO insurer overall when the HMO is filing for their license or filing for a service area expansion and when the PPO insurer is filing its' managed care product. Insurers with PPO products historically have been approved state wide by way of their license process. In both scenarios, we require the insurer to identify the provider network applicable to the product when the product is filed for approval and to demonstrate network adequacy. It has been infrequent when there is a specific network of providers applicable to a specific product and even more so historically to specific healthcare services. Yes, with significant changes in provider network make up and the addition of or deletion of specific networks to or from the insurer must also be filed with DOI/LAH.
- If yes, does DOI review those filed standards, and is there some reasonability test?
  - Yes. There is a review done by LAH analysts when changes are filed, however, there are no specific established criteria in law or regulation to measure against. The analyst, who does have knowledge of the typical medical service access of residents in various geographic areas in N.C., applies a reasonable test to the data provided.
  - Geo Access maps are sometimes provided/ requested by staff to further depict providers in specific or state wide areas with which the insurer has contracted.
  - HMO insurers are required to report interim negative changes in the overall provider network and administratively DOI requires PPO insurers to also report such changes, which includes a statement from the insurer as to impact and what their corrective action plan is to bring the network back into compliance with their adequacy standards.

- What happens when complaints are made about provider network in-adequacies or not reasonably available?
    - These complaints are typically filed by the insureds/patients to our Consumer Services Division. They are handled as expediently as the situation warrants depending upon the need for service being emergent, urgent, or routine, by contacting the insurer, by phone, email, or in writing. These are DOI efforts to assist the consumer by encouraging the insurer to review the case for corrective action for the complainant insured. Subsequently, the insurer may be required to demonstrate why their network provider availability failed and to determine if further network development or provider contracting effort is needed to alleviate the potential of re-occurrence.
    - Further, required periodic market examinations are conducted by the DOI and the frequency and type of complaints are used as exam focus activity. In some circumstances target exams are conducted when complaint activity appears to be sudden and frequent in numbers.
    - Exam activity can result in the insurer taking corrective action revising procedures as necessary but can also carry other sanctions such as fines and ultimately restriction or revocation of the insurer's license to do business in NC.
    - These compliance activities and requirements are still effective for the 2017 plans currently being filed.
    - 3 companies have filed products with CMS and NC DOI for consideration of qualification, i.e. QHP, for the 2017 plan year for on and off the FFM (Exchange). Rates are due today May 23 but will be confidential until released by CMS.