

# Regulation of Provider Networks in Response to COVID-19

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In public health insurance programs, regulators use network adequacy standards to ensure that health plans provide enrollees with adequate access to care. Standards are based on provider availability, anticipated enrollment, and patterns of care delivery, all of which are affected by the ongoing coronavirus disease 2019 (COVID-19) pandemic. COVID-19 affects how individuals in public health insurance programs access, pay for, and utilize health care beyond the pandemic. Regulators may need to modify network adequacy standards and monitoring processes to ensure beneficiary access in this changing health care landscape, particularly in light of prior work showing that many plans have narrow networks<sup>1-3</sup> and that network design affects beneficiary access to care.<sup>4-8</sup> We provide an overview of federal and state network adequacy standards and discuss how regulators may adapt these standards and accompanying monitoring processes in response to COVID-19.

## Overview of Network Adequacy Standards

Network adequacy can be measured in several ways: the number of providers contracted by a health plan for a set of critical specialties, provider capacity (eg, number of beds, wait times to see a provider), and/or geographic coverage of the network (eg, maximum travel time/distance to a provider). Within this framework, regulators have developed network adequacy standards to monitor provider networks for Medicaid managed care, qualified health plans (ie, exchange or Marketplace plans), and Medicare Advantage (MA) plans.

The 2016 Medicaid Managed Care Final Rule required that states propose time/distance standards for a minimum set of provider specialties.<sup>9</sup> Additionally, several states include quantitative measures of provider capacity, such as appointment availability and wait times.

States are tasked with primary oversight of network adequacy for qualified health plans.<sup>10</sup> Although a few states, such as Colorado,<sup>11</sup> Delaware,<sup>12</sup> Idaho,<sup>13</sup> and South Dakota,<sup>14</sup> have established quantitative network adequacy standards for qualified health plans, many states simply rely on their criteria for commercial health plans. Criteria vary by state, but typical commercial criteria include a subset of

## ABSTRACT

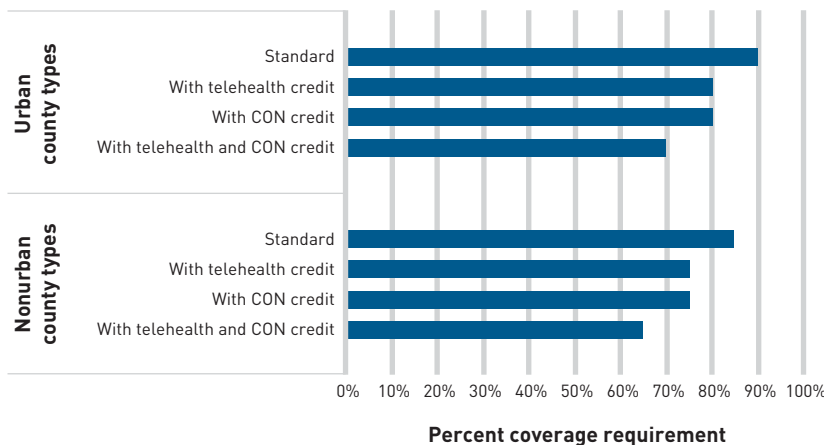
In public health insurance programs, federal and state regulators use network adequacy standards to ensure that health plans provide enrollees with adequate access to care. These standards are based on provider availability, anticipated enrollment, and patterns of care delivery. We anticipate that the coronavirus disease 2019 pandemic will have 3 main effects on provider networks and their regulation: enrollment changes, changes to the provider landscape, and changes to care delivery. Regulators will need to ensure that plans adjust their network size should there be increased enrollment or increased utilization caused by forgone care. Regulators will also require updated monitoring data and plan network data that reflect postpandemic provider availability. Telehealth will have a larger role in care delivery than in the prepandemic period, and regulators will need to adapt network standards to accommodate in-person and virtual care delivery.

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TAKEAWAY POINTS

- The coronavirus disease 2019 pandemic will have 3 main effects on provider networks and their regulation: enrollment changes, changes to the provider landscape, and changes to care delivery.
- ▶ Plans will need to adjust their network size to accommodate increased enrollment or increased utilization caused by forgone care.
  - ▶ Regulators will also require updated monitoring data and plan network data that reflect postpandemic provider availability.
  - ▶ Telehealth will have a larger role in care delivery than in the prepandemic period, and regulators will need to adapt network standards to accommodate in-person and virtual care delivery.

FIGURE. Medicare Advantage Beneficiary Coverage Requirements<sup>15,a</sup>



CON, Certificate of Need.

<sup>a</sup>The Medicare Advantage beneficiary coverage requirements are detailed in the CMS final rule “Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program” published on June 2, 2020.<sup>15</sup>

standards for provider and facility specialties, minimum number of providers, geographic access standards, and appointment wait times.

MA network adequacy criteria comprise the most comprehensive set of standards compared with those for state Medicaid or qualified health plans. CMS measures (1) the minimum number of providers required in a county based on the penetration of MA plans in counties with similar population and density and (2) a sufficient number of providers to ensure that at least a specified percentage of beneficiaries have access to at least 1 of each provider and facility type within a maximum time/distance traveled based on the urbanicity of the market. Historically, plans have been required to cover 90% of beneficiaries for these 2 standards.

As part of the final rule published June 2, 2020, making technical changes to the MA program, CMS lowered to 85% the proportion of beneficiaries in nonurban counties that should have access to a provider within the maximum time/distance.<sup>15</sup> Further, MA plans are eligible for a 10-percentage-point credit toward the proportion of beneficiaries residing within required time/distance standards when they contract with selected telehealth providers. The following

provider specialties are among those that MA plans can contract with for telehealth services and obtain a credit toward their network determination: dermatology, psychiatry, cardiology, otolaryngology, neurology, ophthalmology, allergy and immunology, nephrology, primary care, gynecology/obstetrics, endocrinology, and infectious diseases. Finally, MA plans are eligible for an additional 10-percentage-point credit for each facility type or clinical specialty included in MA network adequacy criteria that is subject to state-level Certificate of Need requirements (Figure<sup>15</sup>).

Effects of COVID-19 on Developing and Monitoring Provider Networks

We have identified 3 primary considerations for monitoring provider networks in response to the COVID-19 pandemic: (1) insurer and regulator considerations for enrollment surges, (2) the changing landscape of available providers as a result of COVID-19, and (3) how COVID-19 has systemically changed the delivery of health care.

**Enrollment surges.** The economic downturn from COVID-19 will increase enrollment in critical public health insurance programs. When individuals lose employer-sponsored insurance, they may choose to enroll in a qualified health plan or, if they meet the eligibility criteria, they may enroll in Medicaid coverage. Economic downturns also increase the number of individuals who apply for and

receive Social Security Disability Insurance (SSDI).<sup>16,17</sup> After 24 months of eligibility for SSDI, individuals may enroll in Medicare coverage. Increases in enrollment will require plans to increase the breadth of their provider networks or increase the capacity of their existing networks. Job loss–driven enrollment increases in Medicaid, qualified health plans, and eventually MA plans will mean that public payers cannot rely on historical enrollment projections to determine the minimum number of providers. Policy makers will need to make sure that their existing minimum provider thresholds ensure sufficient capacity for increased enrollment or update these thresholds to secure adequate access to care for additional enrollees. In instances in which it is not feasible to quickly change minimum number standards, regulators may rely on increased monitoring activities, such as “secret shopper” calls to monitor wait times.

**Changes to provider landscape.** To slow the spread of COVID-19, localities issued emergency public health orders, including physical distancing rules and prohibitions on elective procedures. Additionally, many individuals chose to forgo medical care to reduce their risk of exposure to COVID-19.<sup>18</sup>

Many outpatient practices temporarily closed in response to COVID-19; some may close permanently due to the financial strain, and others may be purchased by a larger organization.<sup>19,20</sup> Small and rural hospitals, which were already financially vulnerable before COVID-19, may also close.<sup>21,22</sup> This will change the number and location of providers and hospitals available to participate in provider networks. Practice acquisitions may also consolidate negotiating power among a more limited number of provider practices. Insurers and regulators will need to ensure that shuttered practices and hospitals are not included in provider directories or submitted to regulators in plan oversight materials (such as the MA Health Service Delivery [HSD] tables).<sup>23</sup>

Regulators often compare contracted networks of providers to the landscape of providers serving a market.<sup>23</sup> Regulators will need to update their data files documenting provider availability to capture post-COVID-19 changes. Data lag for files such as Physician Compare and the National Plan and Provider Enumeration System (NPPES) means that these data sources will likely be an inaccurate source of provider office location information post pandemic. Although plans are expected to maintain current provider directory and network information, audits show that plan data are often inaccurate.<sup>24</sup> As a result, claims data from after the pandemic will be the most accurate and timely source of provider practice location information. Claims data from the period prior to the pandemic can provide a reliable source of information about provider specialties. Relying on data from the height of the pandemic, which will reflect disruptions in delivery patterns, including temporarily closed practices and primary care or office-based specialists temporarily serving in the inpatient setting, could lead to inadequate or less accessible networks, or erroneous assumptions about provider services and locations.

**Changes to care delivery.** In response to the COVID-19 pandemic, providers have transitioned to delivering many nonemergency/outpatient physical and mental health visits through telehealth.<sup>25</sup> From the week of March 2, 2020, to the week of April 13, 2020, telehealth utilization for Medicare enrollees increased by more than 11,000%, from 11,000 beneficiaries to more than 1.3 million beneficiaries receiving care through telehealth.<sup>26</sup> Insurers have supported this transition by rapidly moving to increase reimbursement for telehealth services and by loosening payment rules for the types of care that can be delivered via telehealth.<sup>27,28</sup> States have also loosened licensing laws, e-prescribing laws, and written consent laws to allow health professionals to deliver additional services through telehealth.<sup>29</sup> It is unlikely that telehealth utilization will return to pre-COVID-19 levels, and plans are likely to seek a greater role for telehealth in their networks.<sup>30</sup> Plans may prefer to partially replace in-person care with telehealth visits and narrow in-person networks accordingly. To maintain beneficiary access, policy makers will need to ensure that networks retain sufficient capacity through both telehealth and in-person visits. The federal government and states may consider making permanent the temporary waivers that enabled broader care delivery through telehealth.<sup>27</sup> In the June 2020

final rule,<sup>15</sup> CMS loosened in-person network standards for MA plans that offer telehealth. State regulators may want to follow a similar approach for Medicaid managed care and qualified health plans.

Many individuals forwent care during the initial months of the pandemic.<sup>18,31,32</sup> As the pandemic subsides, the elective surgeries, screening procedures, and routine care that individuals put off during the pandemic will resume. There may also be an increase in utilization as a result of complications from forgone care for chronic conditions. Narrow networks with limited provider capacity may be insufficient to address the surge in enrollee demand for care. As described earlier, regulators may need to increase minimum number requirements or increase monitoring.

## Conclusions

COVID-19 has dramatically changed health care delivery and will have effects on access to, and utilization of, health care services beyond the pandemic. Regulators that oversee provider networks for public insurance plans may need to take a more active role in adapting and using network adequacy monitoring tools for the next several years. ■

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