URAC Issue Brief:  
Best Practices in Network Management

Introduction

As consumers enroll in health plans through newly formed Health Insurance Marketplaces, public concern has arisen over the adequacy of the provider networks created by Qualified Health Plans (QHPs). This issue brief examines the consumer protection principles underlying URAC’s Health Plan standards related to the network adequacy requirements of QHPs and describes commonly occurring industry practices employed by health plans to meet these requirements.

URAC’s standards reflect industry practices regarding the development, examination and management of a health plan’s network of providers with an emphasis on ensuring that consumers are protected from unfair and unsafe practices. Since there are no commonly accepted definitions for the minimum number or types of providers that should be included in a network within a given geographic area, URAC standards focus on ensuring that a health plan creates a system to constantly monitor its existing network to ensure it is meeting the clinical needs of its enrolled population. Consumers are also assured of access to a formal complaint and appeal process within the health plan through URAC’s standards. Furthermore, URAC accreditation independently validates that the outcome of a health plan’s formal complaint and appeal process are actionable tasks that ensure the health plan is constantly working to evaluate and modify their network to meet the needs of their population.

Since URAC’s creation nearly twenty-five years ago, all of our accreditation programs have included a thorough and ongoing emphasis on consumer protection and patient safety within our standards. Our internal investigations of health plans operations further assure that consumer needs and patient safety are continually being evaluated and addressed.

Consumer Protection Principles Underlying URAC Network Management Standards

- Health plans must have written policies and procedures for recruiting clinicians to their network, credentialing providers, and managing their medical network.
- Health plans are responsible for documenting the geographic and demographic make-up of their enrollees and creating provider networks that are accessible and deliver quality medical care.
- Consumers must be given an appeal process whenever they have financial responsibilities for out-of-network care.
- Consumers must receive clear communications on how to access care both outside and inside the network, including preventive, urgent, and emergency care.
- Health plans must review information on an ongoing basis that would indicate problems with quality, access, or adequacy of their provider network such as enrollee complaints and appeals.
Affordable Care Act Network Adequacy Requirements

The Affordable Care Act requires QHPs to ensure their provider network meets the following requirements:

- Includes essential community providers;
- Maintains a provider network that is sufficient in the number and types of providers, including mental health and substance abuse services;
- Assure that all services can be accessed without unreasonable delay; and
- Prohibits limiting enrollees’ benefits or access to providers based on health status-related factors.

States often have additional regulatory requirements regarding network adequacy that are typically addressed by requiring health networks to include a specific number or type of providers in their network or by requiring health plans to meet specific time and distance standards which assess how far enrollees must travel to receive medical treatment. This is especially common in Medicaid and Medicare managed care programs.

How Does URAC Ensure Network Adequacy?

Accrediting bodies recognized by the Department of Health and Human Services, such as URAC, are responsible for confirming that issuers of QHPs have formal policies and procedures, including a robust compliance program, in place to address all regulatory and Health Insurance Marketplace requirements. The QHP compliance program must address monitoring the medical network, timely access to care, and reviewing responses to enrollee complaints. If the QHPs' performance in these areas is deficient, URAC oversees the development of a QHP corrective action plan and confirms through follow-up review that the corrective action plan has been successfully implemented. In addition, URAC ensures that its accredited organizations have the proper internal mechanisms in place to build, manage, and evaluate their networks with respect to the populations they seek to serve.

URAC’s Health Plan accreditation standards incorporate requirements that directly address network management. In addition, QHPs are required to conduct Consumer Assessments of Healthcare Providers and Systems (CAHPS) surveys of members experience with their health plan and the providers serving within that network. QHPs are also required to conduct ongoing analyses of consumer complaints, provide an online directory of providers that clearly indicates providers that are not taking new patients, and communicate patients’ appeal rights and responsibilities in plain language.
URAC Standards Addressing Network Management

**Scope of Services:** URAC Standard P-NM 1 ensures an organization defines the scope of its services with respect to the types of services offered within the provider network and the geographic area served by the provider network.

**Explanation:** This standard verifies that the organization (plan) is capable of analyzing the population being served by the network. This standard requires an organization to describe its network and include demographics or census data that describes the composition of the population served. For example, some networks may serve primarily pediatric or geriatric populations, rural or urban areas, and other communities that may have specific needs. Plans must also indicate the specific type of coverage plans (e.g., HMO, PPO) that are included in the geographic area that network represents.

**Why This Is Important:** This standard confirms that a plan has the process in place to establish and assess the requirements of the service area, in terms of both population demographics and geographic area, being served by a network.

**Access and Availability:** URAC Standard P-NM 2 requires a provider network to establish goals, measure actual performance in comparison to those goals and report the results to the organization’s quality management committee (QMC) and make improvement where necessary to maintain the provider network and meet contractual requirements.

Applicant organizations are reviewed to ensure that a robust internal system is in place to support compliance with applicable state and federal network adequacy regulations as well as the contractual requirements of clients and purchasers. This standard also requires a provider network to demonstrate that it understands the number and types of providers eligible to provide covered medical benefits compared to current and potential enrollees.

The goals set by the organization are expected to include:

- maximum time and distance to provider
  - taking into consideration counties designated as large metro, metro, micro, or rural service area (based on population & density parameters);
- appointment availability;
- minimum provider-to-enrollee ratio;
- member wait times for various types of care (preventive, symptomatic, urgent, and emergency); and
- patient panel sizes.
Under this standard an organization is expected to monitor its network using a variety of techniques that can include:

- network software (i.e., Geo-Access reports),
  - maps of service areas that show where different provider types are physically located;
- secret shoppers,
  - services that pose as consumers and test wait times, availability of services within the network); and
- staff that gather demographic and geographic data on the plan’s network of providers and how well it matches to enrollees locations and needs.

An organization is also expected to use bellwether indicators to monitor its network which may include:

- use of out-of-network services to target potential access issues;
- information about disenrollment; and
- provider complaints on referrals and emergency room utilization.

This standard also requires an organization to implement, as needed, a corrective action plan based on established goals and the organization’s monitoring efforts.

An organization’s corrective action plan should:

- reference a list of corrective action plans that address both current and past resolved issues;
- clearly designate the goal(s) not met and the strategy for resolving the problem(s);
- contain a timeline of events and deliverables;
- indicate the individual(s) responsible and staff assigned to resolving the designated problem(s);
- include the analysis and resolution of the identified problem(s); and
- demonstrate efforts to track trends in order to report to appropriate internal and external authorities.

Explanation: This standard verifies that an organization is appropriately establishing goals with respect to consumer access and availability of the provider network, actively monitoring and measuring performance against those goals, and taking action to improve that performance where needed.

Why This Is Important: This standard ensures that the health plan is actively monitoring on an ongoing basis the performance of its network, comparing the network capacity to current and potential future enrollee needs, and sharing these findings with its internal Quality Management Committee (QMC) for further action, if appropriate. Moreover, URAC QHP standards require that the organization empowers an internal QMC to oversee these activities and that those committees include input from providers in the network. The information collected through implementing these standards can serve as the basis for making cost and patient outcomes data available to consumers, in addition to ensuring appropriate access to care.
**Provider Selection Criteria:** URAC Standard P-NM 3 requires an organization to establish provider selection criteria that address quality of care, quality of service and the business needs of the organization.

An organization is expected to specify, in its criteria for quality of service requirements, specific hours of operation, patient panel size, or alternatively maximum wait times. The selection criteria may also address the specific needs of the plan’s consumers.

   **Explanation:** This standard is meant to validate that an organization is clearly communicating to medical providers the criteria and requirements that will best meet the needs of the plan’s enrollees in order to ensure appropriate access to medical care.

   **Why This Is Important:** This standard ensures that the organization has a mechanism to inform providers as to what is expected to participate in the network.

**Out of Network and Emergency Services:** URAC Standard P-NM 4 requires, to the extent established by its covered benefits, that the organization implements written policies that establish consumer access to covered services that are not available from participating providers in addition to emergency care both within and outside the organization’s service area.

   **Explanation:** Organizations have an obligation to provide for consumers’ medical care when necessary care is not available within the network or when the consumer has a medical emergency within or outside of the organization’s service area.

   **Why This Is Important:** This standard validates that an organization has a plan in place to meet its obligation to provide all necessary care and for the provision of emergency medical services when such services are not readily available within the network. The procedures must be made available to consumers in plain language.
URAC Standards Address Patient Appeal Rights

**Non-Certification Appeals Process:** URAC Standard P-HUM 31 requires the organization to implement and maintain, through written policies and procedures, a formal process for considering appeals of non-certifications or denials of covered services.

Specifically, an organization must maintain and comply with written policies and procedures that:

- allow appeals where non-acute medical services have been denied and provide a review by a licensed physician with 45 days;
- provide for urgent medical appeals within 72 hours for cases involving urgent care;
- a clear description of the appeal process including the rights of patients, providers, or facility rendering service to make such an appeal; and
- explicit time frames for each stage of the appeal resolution process.

**Explanation:** This standard requires the organization to implement an appeals process for patients (or those representing the patients’ interest) regarding a claims decision with respect to the care they receive. URAC reviews the organization’s compliance with these written policies and procedures to protect both the rights of appeal and consumer access to appropriate care. Appeals for urgent care must be reviewed within 72 hours, while routine care must be reviewed within 30 calendar days unless otherwise dictated by state law.

**Why This Is Important:** This standard validates that a patient can appeal, through a formal process, any medical necessity denial of covered services. With respect to network adequacy, this standard allows a health plan to track any trends with respect to the utilization of out-of-network services alerting them to address any deficiencies of care in the network. For example, if an organization noticed an elevated number of appeals focused on out-of-network hip replacements, this would alert them to a potential shortage of orthopedic surgeons in their existing network of providers.

**Appeals Process:** URAC Standard P-HUM 32 requires an organization to include as part of the appeals process:

- an opportunity for the patient, provider or facility rendering service to submit written comments, documents, records and any other related information to the case;
- inclusion of all information in the review and decision of the case that was submitted during the appeals process; and
- the implementation of the first level clinicians decision if the appeal overturns the initial denial.

**Explanation:** This standard delineates specific requirements an organization must include in its appeals process to ensure that the patient (or those acting in the patient’s interest) can submit information of importance to the case and that the information submitted is considered in the appeal decision.

**Why This Is Important:** This standard requires the organization to include and review all relevant information before rendering an appeal decision. The standard also ensures that a patient receives the appropriate care needed should the initial service be denied.
URAC Standards Addressing Regulatory Compliance

**Regulatory Compliance:** URAC Standards CORE 4 requires the organization to implement a regulatory compliance program that tracks applicable laws and regulations in the jurisdictions where the organization conducts business, ensures the organization’s compliance with applicable laws and regulations, and responds promptly to detected problems and takes corrective action as needed.

**Explanation:** URAC validates that the organization has adequate regulatory compliance mechanisms in place to identify and comply with appropriate regulations.

**Why This Is Important:** This standard requires the organization to implement a regulatory compliance program that identifies, tracks and ensures compliance with applicable laws and regulations to protect consumer interests as defined by regulation.

**Compliance Program:** URAC Standard P-CP 1 delineates the specific activities required for a robust regulatory compliance program. The standard requires the internal compliance controls to include

- appointment of a compliance officer;
- designation periodic review and update of compliance program training/education;
- regularly scheduled periodic internal monitoring and auditing;
- periodic review and analysis to determine if any benefits, policies or UM protocol impact compliance;
- communication plan that notifies delegated contractors regarding changes impacting compliance; and
- a thorough review of state and federal regulations related to HIPAA, parity of health care services, and a review of potential fraud, waste and abuse.

**Explanation:** This standard delineates requirements for an organization’s regulatory compliance program. This standard helps ensure an organization has all the qualities of a successful compliance program. Best practices under this standard include a plain language summary of relevant state and federal laws which is available to all staff for reference.

**Why This Is Important:** This standard sets the criteria for an organization’s successful compliance program by identifying and ensuring adherence to applicable laws and regulations that protect consumer interests as defined by regulation and the organization from legal challenges.
**Conclusion**

The accreditation process ensures that rigorous consumer and patient safety protections are in place within QHPs to meet current regulatory requirements, demonstrate their ability to meet industry best practices and provide appropriate access to medical services. The specific accreditation requirements outlined in this issue brief are further supported by a network of supporting obligations such as consumer surveys, ongoing analysis of consumer complaints, and easily understood communications to enrollees.

As oversight continues, state and federal regulators may choose to develop additional requirements for QHP provider networks, which would then be incorporated into URAC’s standards. Recognizing the role of state governments in the continuing implementation of the ACA, URAC’s Standards Addendum process allows for the inclusion of program-specific requirements into a set of accreditation standards. URAC is available to continue its work with state and federal regulators to ensure consumer access to quality healthcare.