Narrow Networks Help Create Value in a More Regulated Healthcare Landscape

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5 characteristics of thriving narrow networks

Read this and learn:

- How to better define narrow networks in the new healthcare landscape
- The characteristics of how to operate a successful narrow network
- Regulatory considerations impacting provider alignment models
- Critical success factors for winning in the future healthcare environment
- Factors contributing to the growth of provider-health plan alignment

Healthcare's constant evolution revolves around defining, developing and demonstrating value to the marketplace. To achieve value and comply with regulatory standards, hospitals, physicians and health plans are now utilizing narrow networks. Narrow networks are an exclusive group of high-value providers and health professionals (e.g., exclusive provider organizations) for a defined patient population that limits member choice and increases affordability through reduced premiums. Highly regulated public and private insurance exchanges are currently providing a venue for narrow networks to be sold and create transparent choices for members based on value. This increase in consumer choice between networks will require a new strategy for the health plan and provider organizations to work collaboratively in order to compete for new members and market share, under a value-based system of care. As these networks become narrower, premiums can become smaller, creating an extremely competitive environment; however, exclusivity must be balanced with access.

Narrow networks and the utilization of exclusive provider organizations

Narrow networks are nothing new to the healthcare industry. In the 1990s, narrow networks were defined as preferred provider organizations or health maintenance organizations. These organizations would charge access fees to their enrollees and even to their provider members, marketing their networks as affordable, quality networks of healthcare professionals. Many people believe HMOs were not as successful because the physician and hospital fee schedules were primarily volume-based. Others believe that at the time, information technology in healthcare was not capable of effectively demonstrating quality across a defined population. Still others believe that patients ultimately rejected the notion of a "gatekeeper" that might restrict their access to care. However, with a new value-based payment methodology, greater patient burden of paying for care and an evolving health care technology industry, narrow networks are getting a renewed visibility.

The "new" narrow networks will require the following characteristics to thrive:

► A defined population to manage. One critical feature of narrow networks is also an unpopular one: They require that enrollees receive care only from a select group of providers. This allows narrow
networks to manage patient information, costs and performance across all providers. However, access to care is an issue for consumers. For example, a federal rule proposed in 2014 would require narrow networks used with health insurance exchanges to include 30 percent of community safety net and essential providers. Federal legislation also continues to strengthen adequacy requirements to manage appropriate access to care. Broadening a network too much, however, can make it very hard to control costs and improve quality.

- **An IT infrastructure capable of population health management.** Population health management is a model for helping providers and payers assess the populations they serve across the continuum of care. To help this model succeed, health systems, physicians and health plans are in the process of enhancing their data, risk and analytical management of information so they can effectively demonstrate improvement across evidence-based guidelines. This will allow narrow networks to focus on making meaningful care redesign decisions to improve care to patients.

- **An incentive-based payment model.** Approximately 11 percent of payments to physicians and health systems are based on performance or cost reduction. This number is expected to increase with each improvement initiative.

- **Provider–health plan alignment.** Each stakeholder has strengths to offer in a partnership model. Providers allow the local initiatives to be "physician-led" and therefore can effectively change the care models based on increased coordination and transparency. Health plans bring data, reporting and risk management capabilities that allow for data-driven decisions.

- **Consumer choice and transparency.** Consumers are demanding more transparency in the marketplace and dictating many of the pricing decisions made by the narrow networks. Therefore, if a narrow network has high premiums, it must justify this to the consumer through greater benefits, access to care and, most important, quality. Although consumers have flexibility to initially choose a network, their choices are limited once they select a plan. There is mounting consensus from health plans and providers that narrow networks work only if they are able to remain exclusive to a select number of providers. With some exceptions around medical necessity, there will be limited choice for consumers once they enter the network.

As health systems, physicians and health plans prepare for value-based payment models and new health insurance exchanges, the strategy of choice will be exclusive provider organizations. Successful organizations will have effectively aligned incentives, propelled physicians into leadership positions and created a disciplined approach to tracking outcomes through performance across evidence-based guidelines. Creating value is a never-ending cycle of improving performance, and many of these networks are in their infancy. To grow, they require assistance from health plans that can leverage their strengths of data management, actuarial and risk analysis, and information technology.

Narrow networks work only if patients stay within the exclusive provider networks. Therefore, the "narrow" (exclusive) classification brings multiple regulatory issues front and center for many health care discussions.

**Regulatory issues and considerations**

As narrow networks, exclusive provider organizations and additional products are created by health systems, physicians and health plans, many regulatory issues impact implementation. Some of these federal requirements are old, while others are relatively new and based on the Patient Protection and Affordable Care Act requirements for non-grandfathered products. One intent of PPACA is to protect the patient, providers and health plans from a breakdown in the quality of care being delivered as costs are reduced.
A few regulatory issues to consider include:

► **Stark Law.** This law prevents physicians from referring members to an organization in which they are financially invested. While some narrow networks are actually physician-owned entities, others have created financial partnerships with physicians. Therefore, narrow networks can create unintended consequences and/or barriers to success based on regulatory guidelines. Physicians and health systems must be able to demonstrate quality improvement across evidence-based guidelines as the prerequisite to any shared savings or financial distributions based on cost reduction.

► **Anti-Kickback Statute.** This prevents financial rewards or incentives to healthcare professionals for referrals. The exclusive aspect of exclusive provider organizations is a critical part of the equation. Keeping patients within the defined network is essential for controlling the healthcare costs of the defined population. As narrow networks become smaller and access to information becomes easier, the importance of a provider's ability to demonstrate its value is extremely high.

► **Essential health benefits.** The PPACA includes a list of types of healthcare services required within narrow networks: ambulatory patient services, emergency services, hospitalizations, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, lab services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision services). Therefore, narrow networks must include health care professionals who provide this broad range of services, while also keeping costs down. The extent of required services can make it hard for networks in some rural and urban areas to mandate the appropriate levels of quality and efficiency as a prerequisite to inclusion into the network, due to the limited availability of high-quality care. Without the ability to control quality and efficiency, the network may be forced to increase its premiums to compensate for a higher operational risk.

► **Medical liability.** No one doubts that healthcare costs are increasing at an alarming rate. Narrow networks are a means to curb the increase and control costs. Healthcare costs are the critical driver of narrow networks. However, costs should not be decreased at the expense of quality. Quality processes and outcome-based measures must be seen as essential to narrow-network adoption and used as prerequisites to cost-control measures.

► **Civil Monetary Penalties Law.** The American Hospital Association states that this law prohibits "payments from a hospital that directly or indirectly induce physician(s) to reduce or limit services to Medicare or Medicaid patients." Limiting care to patients is a common fear about future healthcare design and this regulation is a way to prohibit incentives that drive adverse behavior.

► **State legislature reform.** Federal laws are the ones making headlines, but state legislatures are also becoming very active. For example, a state insurance commissioner is requiring that "both qualified health plans and health plans offered outside of the exchange must have networks that at a minimum ensure access to covered services without unreasonable delay and address the specific needs of the populations served." State reform is taking place across the country and needs to be monitored on a case-by-case basis.

**Conclusion**

Narrow networks are an essential component of efforts to reduce healthcare costs. But they must determine effective and meaningful ways to work within the evolving regulatory landscape as defined above. Health reform and PPACA architects will continue to learn from the past, reevaluate policy, and expand or reduce provisions in ways determined by lawmakers and the influence of their constituents. Due to this unpredictability, healthcare systems, physicians and health plans will need to structure
themselves in a way that effectively aligns to create value through demonstrated quality and service at a reduced cost. The critical success factors below can help guide each stakeholder's decision-making:

- Allow physicians to lead
- Measure in-network providers using a transparent and credible methodology
- Apply data-driven decision-making capabilities
- Select partners to help with technology and access to care requirements
- Consult with legal counsel, fair market value firms and content experts on a regular basis

As health professionals and health plans assess new strategies and alignment models, they must do so within the confines of a new and evolving regulatory landscape. This landscape has proven extremely volatile over the past few years and will continue to change based on regulatory and public pressure.

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