Striking a Balance: 
Mental Health Provider Network Adequacy under 
Health Care Reform

JOEL E. MILLER
Executive Director and Chief Executive Officer
American Mental Health Counselors Association

STUART YAEL GORDON, J.D.
Director, Policy and Health Care Reform
National Association of State Mental Health Program Directors

ROBERT W. GLOVER, PH.D.
Executive Director
National Association of State Mental Health Program Directors

September 2014
Alexandria, Virginia

Seventh in a Series of Eight on Affordable Care Act (ACA) 
Implementation

This issue brief was sponsored by NASMHPD and the Substance Abuse 
and Mental Health Services Administration (SAMHSA)
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Executive Summary

This issue paper provides an overview of network adequacy requirements outlined in the Affordable Care Act (ACA) for qualified health plans (QHPs) and other standards applied in private insurance markets, Medicaid, and Medicare. We also recommend key issues for mental health stakeholders and advocates to consider when advocating for strong network adequacy standards for QHPs in the Marketplaces (also known as “Exchanges”).

In addition to expanding health insurance coverage for millions of people, the ACA and the regulations adopted to implement it require that health plans participating in Marketplaces meet network adequacy standards. Section 1311(c)(1)(B) of the ACA requires the Secretary of Health and Human Services (HHS) to “set standards to ensure a [QHP] network has a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under § 2702(c) of the Public Health Service Act (PHSA)).” Unfortunately, the cited subsection of the PHSA does not actually define network adequacy.

One generally accepted definition of network adequacy is “the ability of a health plan to provide enrollees with timely access to a sufficient number of in-network providers, including primary care and specialty physicians, as well as other health care services included in the benefit contract.” The ACA’s implementing regulations require the inclusion of mental health and substance use disorder providers, which would seem to mandate the inclusion of psychiatrists, clinical mental health counselors, psychologists, and marriage and family counselors.

Because the ACA’s essential health benefit (EHB) package mandate requires a minimum level of benefits for all health plans, enforcing and strengthening the adequacy of provider networks is critical to ensuring that the millions of people who are newly insured through the ACA can easily access their covered benefits.

ACA Network Adequacy Requirements for QHPs

The ACA directs the U.S. Department of Health and Human Services (HHS) to develop criteria to certify health plans sold in Marketplaces. These criteria aim to ensure each plan:

- provides a sufficient choice of providers;
- includes “essential community providers (ECPs)” to serve predominately lower-income and medically underserved individuals; and
- provides information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers.

In proposing its network adequacy regulations for the Marketplaces, HHS said it recognized that network adequacy standards should be appropriate to States’ particular
geography, demographics, local patterns of care, and market conditions. Therefore, to ensure that Marketplace network adequacy requirements are appropriate for QHP issuers and reflect local patterns of care, CMS proposed in new regulation 45 CFR 155.1050 that each Marketplace ensure that enrollees of QHPs have a “sufficient” choice of providers without unreasonable delay. It said this broad standard would afford the Marketplace significant flexibility to apply the standard to QHPs in a manner appropriate to the State’s existing patterns of care, establishing specific standards where necessary and leveraging existing State oversight and enforcement mechanisms. vi

HHS, in the preamble to the final regulations, noted that “nothing in the final rule limits a Marketplace’s ability to establish more rigorous standards for network adequacy.” HHS said the minimum standard was intended to allow sufficient discretion to Marketplaces to structure network adequacy standards that are consistent with standards applied to plans outside the Marketplace and are relevant to local conditions, consistent with current State practice. vii

However, HHS also said in the preamble that, while it was reluctant to otherwise require the availability of specific types of providers, it was specifically highlighting mental health and substance use treatment services because it recognized that the EHBs created new demands for access to mental health and substance use treatment services, and that such services have traditionally been difficult to access in low-income and medically underserved areas. By specifying the need to include mental health and substance use treatment providers in the network adequacy standard, it was seeking to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance use services, particularly in low-income and underserved communities. viii To ensure that all services can be accessed without “unreasonable delay,” the final rules issued in March 2012 require QHPs to have provider networks that are “sufficient” in number and types of providers, including those that specialize in mental health and substance use disorder services. ix

With respect to the statutorily mandated inclusion of ECPs, the final regulations mandated that direct that each QHP’s network have a sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP’s service area, in accordance with the Marketplace’s network adequacy standards.  x State regulators would be responsible for establishing minimum contracting standards based on each state’s unique geographic and demographic factors. HHS said in the preamble to the final rule, that nothing in the rule would preclude a Marketplace from identifying specific provider types that are particularly essential in a State. xi

Key Issues for State Behavior Health Agencies, Providers and Consumer Advocates

Traditional network adequacy standards are tied to a fee-for-service, face-to-face model of care. The “time and distance” standards that base access on how far the consumer must go to receive treatment assume care, especially common in Medicaid and Medicare
managed care programs, must be delivered in a face-to-face encounter. For many services, that model is changing. Telehealth technologies make it possible for a provider in one jurisdiction to treat a consumer in another. Value-based purchasing creates teams of providers which should ensure access to an array of necessary providers with the team. Care is being transferred from institutional settings to a home- or community-based setting. In this changing health care environment, new ways can be found to accommodate the needs of consumers and providers.

State Behavioral Health Authorities (SBHAs) should ensure that plan networks are sufficient in number, mix, and geographic distribution of providers to ensure access to all covered mental health and substance use disorder (MH and SUD) services in a timely manner that is not detrimental to the health or well-being of the enrollee. While the overarching principle continues to be that the ACA standards are broad and general, giving states the opportunity to be prescriptive by, for example, limiting enrollee travel times, distances to provider sites, and appointment waiting times, network adequacy should focus also on the quality of care and affordability of care provided in the network, including enrollee out-of-network cost-sharing.

Federal regulatory standards applicable to both Medicaid and Marketplace plans networks are not aligned across the programs that provide affordable coverage. States should take an active approach to developing strategies that ensure that individuals “churning” between Medicaid and Marketplace coverage will have continuity of care from their customary providers. State Medicaid policies provide models of contracting requirements designed to ensure provider continuity of care as eligibility status changes, particularly for individuals undergoing active treatment for an acute or chronic medical condition.xii

I. Policy and Legal Context: Applicable ACA Law and Rules

Section 1311 of the ACA, which is codified at 42 U.S.C. § 18031, charges the Secretary of HHS with adopting regulations that “establish criteria for the certification of health plans as qualified health plans” for the Marketplace. On March 27, 2012, the U.S. Department of Health and Human Services (HHS) published a final rule on the ACA Marketplaces, xiii setting forth the minimum standards Marketplaces must meet, including the minimum requirements for certifying issuers to offer QHPs through the Marketplace.

Under those rules:

- **Marketplaces must ensure that QHPs, at a minimum, ensure a sufficient choice of providers.** The final rule establishes a minimum network adequacy requirement, consistent with the National Association of Insurance Commissioners (NAIC) Managed Care Plan Network Adequacy Model Act, that a QHP must maintain a sufficient number and type of providers, including those specializing in mental health and substance abuse, to assure accessibility to all services without unreasonable delay.xiv The preamble to the rule noted HHS’
intent to ensure sufficient numbers and variety of providers in QHP networks, while maintaining the flexibility of a Marketplace to align with network adequacy standards outside the Marketplace.\textsuperscript{xv} The preamble also recognized that inclusion of MH and SUD services as EHBs would create new demand for additional service providers, which have traditionally been difficult to access for low-income and underserved populations.

- **Staff Model Network Adequacy.** A QHP issuer that provides a majority of covered professional services through staff employed by the issuer or through a single contracted medical group would have to instead, under the final regulations, meet the alternative standard of having a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of the QHP’s contracted medical group and hospital facilities, to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP’s service area.\textsuperscript{xvi}

- **The final regulations\textsuperscript{xvii} and the April 2013 CMS letter to issuers required that each QHP have a provider directory that notes whether or not the provider is accepting new patients.**\textsuperscript{xviii} In the preamble to the final rule, CMS made it clear that it was giving the Marketplaces the flexibility to determine the best way to give potential enrollees access to the provider directory for each QHP, whether through a link from the Marketplace’s website to the issuer’s website, or by establishing a consolidated provider directory through which a consumer could search for a provider across QHPs.\textsuperscript{xix}

- **Each QHP’s network is required to have a sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of ECPs for low-income, medically underserved individuals in the QHP’s service area, in accordance with the Marketplace’s network adequacy standards.**\textsuperscript{xx} ECPs are defined in § 221 of the ACA as health care providers defined in § 340B(a)(4) of the PHSA, and as described in § 1927(c)(1)(D)(i)(IV) of the Social Security Act. Marketplaces have the discretion to set higher, more stringent standards with respect to ECP participation, including a standard that QHP issuers offer a contract to any willing essential community provider.\textsuperscript{xxi} The preamble to the final rule notes that the statutory list of ECPs need not be considered exhaustive and should not be interpreted to mandate that QHPs exclude other providers serving low-income, medically underserved individuals in the service area who might also be included in the QHP’s network.\textsuperscript{xxii}

- **The final rule addresses the potential conflict between two provisions of the ACA governing the inclusion of ECPs in QHP networks.** ACA § 1311(c)(2) provides that QHPs are not required to contract with an ECP that refuses to accept the generally applicable payment rates of the plan. However, another ACA provision, § 1302(g) requires QHPs to reimburse Federally Qualified Health Centers (FQHCs) at each facility’s Medicaid prospective payment system (PPS) rate or, alternatively, a mutually agreed rate at least equal to the QHP’s generally
applicable rate. The preamble to the final rule clarifies that “generally applicable payment rates” means, at a minimum, the rates offered by QHPs to similarly situated providers who are not ECPs.xxiii

For Federally Facilitated Marketplaces and Partnership Marketplaces, HHS set a “safe harbor, in an April 5, 2013 letter to issuers, of 20 percent of ECPs available in the service area. However, that same letter also set a “minimum expectation” for the 2014 coverage year that participating health plans would include at least 10 percent of all ECPs available in their service areas in their provider networks. An issuer that did not meet the minimum expectation, would have to include, on its application for participation in the Marketplace, a description of how the issuer’s provider network(s) would provide access for low-income and medically underserved enrollees and how the issuer would increase ECP participation in the provider network(s) in future years. QHPs also would have to make provider directories available to enrollees online, and in hard copy on request, and indicate when providers are not available to new patients.xxiv

The 20 percent ECP threshold was raised to 30 percent for the 2015 coverage year. In a February 4, 2014, letter to issuers participating in the Federally Facilitated Marketplace in 2015, CMS also warned that issuers must ensure the presence of at least one ECP in each ECP category in each county in the service area, where an ECP in that category is available.xxv Once again, CMS said it would permit issuers who could not meet the benchmark to submit on its application for participation a description of how the issuer’s provider network(s) would provide access for low-income and medically underserved enrollees and how the issuer would increase ECP participation in the provider network(s) in future years. However, CMS also noted that it had only received one such explanation in applications for the 2014 coverage year.

- The ACA requires that all QHPs provide an EHB package that covers at least those benefits under benchmark plan selected by the state, with minimum standard coverage benefits and cost-sharing varying only by plan tier. And there is a similar benchmark plan requirement for enrollees in any Medicaid expansion plan. While individuals already eligible for Medicaid may continue to receive benefits in accordance with traditional state Medicaid plans, the population newly covered by Medicaid must receive a benchmark benefit package that is at least as generous as the state’s chosen benchmark plan EHB level, with nominal levels of cost-sharing. However, because there is a clear public policy interest in maintaining continuity of care for enrollees churning between Medicaid and the Marketplaces, many Medicaid expansion states have expand their traditional Medicaid benefits to align the with more generous EHBs provided to expansion enrollees, according to CMS officials.
NAIC Standards for Network Adequacy

In adopting its initial network adequacy standards, HHS acknowledged the existing National Association of Insurance Commissioners (NAIC) Managed Care Plan Network Adequacy Model Act #74 which, until 2014, had not been revised since October 1996. The 1996 version of the Model Act recommends that an issuer providing a managed care plan maintain a network that is sufficient in numbers and types of providers to assure that all services to covered persons are accessible without unreasonable delay. In the case of emergency services, enrollees should have access twenty-four (24) hours per day, seven (7) days per week. Sufficiency under the NAIC model can be established by reference to any reasonable criteria used by the issuer, including:

- provider-covered enrollee ratios per primary care and specialty provider;
- geographic accessibility;
- waiting times for appointments with participating providers;
- hours of operation; and
- volume of technological and specialty services available to serve the needs of covered persons requiring advanced technology or specialty care.

As of April 2014, 21 states had network adequacy requirements either in statute or regulation. Only seven states had formally adopted NAIC’s Model Act into statute. In most states, the Department of Insurance or Department of Health oversees network adequacy when a managed care plan applies for licensure or as part of a quality assurance assessment. However, to the extent that state regulators provide oversight, it is most commonly in response to consumer complaints.

II. Access to Care in Medicaid Managed Care Plans

Access to health care has been a focus of the Medicaid program since its enactment, with a focus on integrating Medicaid beneficiaries into the general health care system, enabling them to receive care from the participating provider of their choice.

However, Medicaid beneficiaries nationally continue to receive a disproportionate amount of health care from “safety net” providers such as community health centers, public hospitals, and free clinics, while private physicians are more limited in their Medicaid participation. A 2013 study found that about 29.9 percent of office-based physicians did not accept new Medicaid patients in 2011–12. Physicians in community health centers are more likely than others to accept new Medicaid patients, with 94.2 percent accepting new Medicaid patients, although they constitute only 3.6 percent of physicians. Only 33 percent of physicians in primary care are likely to accept new Medicaid patients. Among non–primary care specialties, psychiatrists are less likely than almost all specialties to accept new Medicaid patients, with only 43.8 percent accepting new Medicaid patients. A similar study published a year earlier found that physicians in solo practices are 23.5 percentage points less likely to accept new Medicaid patients.
than physicians in offices with at least ten other physicians. Physicians practicing outside Metropolitan Statistical Areas are 12.9 percentage points (19 percent) more likely than others to accept new Medicaid patients. A third September 2009 study found that black physicians were more likely to accept new Medicaid patients. And, psychiatrists were much less likely to accept new patients regardless of insurance type.

Since the 1980s, states have increasingly used various forms of managed care to establish a network of providers through contracts with health plans and/or providers who agree to accept Medicaid patients and ensure timely access to care. However, because managed care generally requires or favors the use of the MCO’s contracted network of providers, which can be limited, access to specialty care and specialized services can be a particularly serious challenge for Medicaid managed care patients. Conversely, some managed care plans at times provide more access to specialists than is available in traditional fee-for-service programs, but the scope and extent of that access may be state-specific and variable. States have indicated that where an access problem exists, it often parallels a similar problem encountered by those with other types of insurance besides Medicaid.

States have built on federal statutory and regulatory requirements to develop robust criteria and systems for managed care plan certification, procurement, and oversight of key requirements for quality and network adequacy. While Medicaid managed care differs from commercial health insurance with respect to the population served, consumer cost-sharing, benefit designs, and provider networks, many Medicaid enrollees are in plans whose issuers also serve the commercial market.

Federal regulations require states to ensure that covered services are available and accessible to all Medicaid MCO enrollees through a requirement that each plan “maintains and monitors a network of appropriate providers that is ... sufficient to provide adequate access to all services covered under the contract.” MCOs are required to consider a number of factors in establishing networks, including anticipated enrollment, expected utilization, the geographic location of providers relative to enrollees, and physical accessibility for enrollees with disabilities. Females must have direct, in-network access to a women’s health specialist. The federal regulations also require plans to meet state standards for timely access to care and services and make services available 24/7 when medically necessary. If adequate access to services is not available in-network to a particular enrollee, the MCO must adequately and timely cover these services out-of-network for as long as the enrollee lacks access.

States typically use provider-to-population ratios, distance, or travel-time from enrollee residence, or wait-time maximums as standards to ensure that MCO networks are adequate. States may also apply different standards for primary and specialty care providers. Many states require or encourage MCOs to contract with health centers, public health departments, and school-based clinics to help ensure adequate access for Medicaid beneficiaries. In most states, in addition to primary care physicians, providers such as women’s health care specialists, nurse practitioners, FQHCs, and physician groups/clinics are recognized as primary care providers for Medicaid MCO enrollees to the degree that
state “scope of practice” laws permit recognition of the particular provider in that capacity.

III. Experience from Massachusetts Commonwealth Care

The success of the health care coverage expansion enacted by Massachusetts in April 2006 and implemented in May 2007 largely shaped the health insurance coverage expansion mandated by the ACA. The Commonwealth Care program itself was a hybrid approach to covering previously uninsured residents that incorporated features of both the MassHealth Medicaid MCO contracts and commercial plans operating in the state.

A 2011 report to the Massachusetts legislature submitted prior to the mandated coverage under the ACA, but four years after implementation of Commonwealth Care, found that adults in Massachusetts had experienced sustained improvements in access to care since implementation of reform. Massachusetts residents continued to indicate, as they had in surveys since implementation, that they were still able to access necessary health care services. Approximately 93 percent of residents had a usual source of care in 2010, an increase from 2009. Of those residents who reported having a usual source of care, more than 90 percent had had that relationship for more than a year and almost a third reported having that relationship for five years or more. Further, 2010 saw a 3 percent reduction in emergency department use by non-elderly adults.

Nevertheless, nearly a quarter of Massachusetts residents reported having difficulty accessing health care in at some point in 2010, according to a survey that year. The most common reason reported for unmet need was cost (about 60 percent), with difficulty getting an appointment being the second most common reasons. Adults with a total household income below 300 percent FPL reported greater difficulty finding a provider who would see them than those at a higher income level. Adults with incomes below 300 percent FPL were less likely to have a usual source of care (84.2 percent compared with 95.2 percent of higher income adults). Among those adults who reported using the emergency department for non-emergent care, three-quarters indicated it was because they needed care after normal physician office hours.

With its December 2008 procurement solicitation, Commonwealth Care strengthened its behavioral health requirements by adding behavioral health access requirements to its 2009 MCO contracts—as well as provisions relating to cultural and linguistic access. The original contract provisions had not had specific behavioral health requirements, but the behavioral health care needs of Commonwealth Care enrollees required access to behavioral health providers more akin, although not identical, to that available to MassHealth enrollees than to enrollees in commercial plans.

The new contract requirements mandated that selected MCOs:

- ensure that enrollees have access to a choice of at least two network behavioral health providers to the extent that qualified willing providers are available;
- develop and implement policies to monitor access and availability of their behavioral health provider network;
- offer access to behavioral health services within 60 miles or 60 minutes travel time from the enrollee’s residence;
- provide emergency services immediately, on a 24-hour basis, 7 days a week, with unrestricted access to enrollees who present at any qualified network or non-network provider;
- provide Emergency Service Provider (ESP) Services immediately, on a 24-hour basis, 7 days a week, with unrestricted access for enrollees who present for behavioral health crisis services;
- provide urgent care within 48 hours for services that are non-emergency services or routine services;
- provide all other behavioral health services within 14 calendar days; and
- develop policies and procedures for the Connector’s prior review and approval that outline how behavioral health providers will have to integrate and coordinate inpatient services admissions, discharge planning, and other utilization management activities.xxxix

In addition, when the program began, there had been issues related to open and closed panels of PCPs. Originally, information about panels was updated weekly by download to a compact disc, but the process was streamlined through a weekly file transfer to keep information more current. Commonwealth Care also clarified that the standard for determining network adequacy of a plan would apply only to open panels, and not to closed or partially closed panels.xl

IV. Narrow Networks

The use of narrower networks as a mechanism to reduce plan costs is not new, and is not limited to plans in the new Marketplaces. In the past, commercial group health issuers have offered narrow network products, largely in response to complaints from employer-based health-care purchasers about rising health costs. Issuers in the late 1980s and early 1990s increasingly offered tightly managed health maintenance organizations (HMOs) that constrained choice of providers in exchange for lower premiums. But these and other access restrictions contributed to a backlash from providers and consumers and led federal and state policymakers to propose minimum standards for the adequacy of provider networks. When attempts at a federal standard for commercial health insurance foundered, many state legislatures filled the gap.

In the individual market, issuers have long had many levers to constrain costs, such as the use of health-status underwriting to avoid covering people with health care needs, benefit exclusions (such as declining to cover maternity care or prescription drugs), annual or lifetime dollar limits on benefits, and high cost-sharing (deductibles of $10,000 or more were not uncommon). Therefore, they have not historically had the same incentives to
narrow provider networks for individual market products. With the ACA removing those savings options for issuers of individual coverage policies, and in the face of concerns that an influx of sicker enrollees would require higher premiums to cover the issuer’s costs, issuers have turned to narrowing networks as the lever of choice for reducing costs and appealing to price-sensitive consumers.

**Current Impetus behind the Narrow Network Strategy**

An issuer that cannot make a bona fide threat to either exclude a provider from its provider network or place it in a disadvantageous cost-sharing tier gives up an important source of leverage in reimbursement negotiations. The threat of excluding or limiting a provider’s network participation facilitates price negotiations in two ways. First, the threat itself serves to moderate the provider’s price demands. But by limiting the network, the participating provider sees additional patient volume and thus higher reimbursement.

While gaining leverage over negotiated prices is the primary reason issuers are turning to limited networks, issuers also report the intention to develop “high-performance” or “value” networks. Providers favored for inclusion in the narrow network not only are willing to provide comparatively favorable prices but also are potentially most capable of meeting issuer objectives for improving quality of care and limiting unnecessary care. For example, issuers are designating Centers of Excellence outside their service areas to which enrollees are encouraged to go for certain elective specialty services. These Centers are chosen because they deliver better outcomes at a lower price than local providers.

**Narrow Networks as a Risk-Selection Mechanism**

Narrow networks can be advantageous to issuers as a risk-selection mechanism because sicker individuals are seen as more attracted to broader network plans. However, over time, this approach could have dangerous consequences, reducing access across the board. The ACA’s risk-adjustment, risk corridors, and transitional reinsurance mechanisms, under which risk is spread in the early years among plans through the pooling of contributions to subsidize plans with higher costs, is intended to largely eliminate any incentive to cherry-pick enrollees, either directly or indirectly. However, the effectiveness of these mechanisms is still to be determined.

If the network overly restricts the choice of provider, excluding those with specialized expertise in treating particular conditions, it can not only compromise the quality of care but also expose consumers to unanticipated and potentially crippling financial liabilities. A lack of transparency about issuers’ network designs can lead to consumers making uninformed decisions in choosing plans, or seeking care outside the plan network or in a higher-priced preferred provider tier with extra cost-sharing. Conversely, some consumers may unwittingly trade a choice of providers for a lower premium, unaware of the risks they take in doing so. A June 2014 Kinsey & Company report found that 42 percent of respondents in a consumer survey who had enrolled in a Marketplace plan and
were aware of the plan’s network type purchased narrow network plans. However, 26 percent of respondents indicated they were unaware of their plan’s network type when they selected the plan.\textsuperscript{xlii}

The McKinsey study found that broad networks (that included at least 70 percent of hospital providers) were available to close to 90 percent of the population in the studied service areas, while narrower networks (with 31 percent to 70 percent of hospital providers) were available to 92 percent of the population in the service area, making up about one-half (48 percent) of all Marketplace networks across the U.S. and 60 percent of the networks in the largest city in each state. Plans that covered care in broader networks saw a median increase in premiums of 13 to 17 percent. Nationwide, close to 70 percent of the lowest-price products were built around narrow, ultra-narrow, or tiered networks.\textsuperscript{xliii}

Similarly, a September 2014 National Bureau of Economic Research (NBER) study of narrow network plans in Massachusetts state employee plans found restrictions in choice of providers led to a 36 percent reduction in health care spending, with the savings reflecting both reductions in quantity of services used and prices paid per service. However, spending on primary care actually rose for consumers switching to narrow network plans; the reduction in spending came entirely from a reduced spending on specialists and hospital care, including care in emergency rooms.\textsuperscript{xliv}

V. Network Adequacy under the ACA

As noted previously, the ACA established the first federal statutory standard for network adequacy in commercial health insurance by requiring plans sold through the Marketplaces to maintain a provider network that is sufficient in numbers 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. That standard also requires Marketplace plans to include in their networks ECPs that serve predominantly low-income, medically underserved individuals.\textsuperscript{xlv}

At the same time, the ACA’s insurance rules raise the stakes for consumers who use out-of-network providers. First, out-of-network cost-sharing does not qualify for ACA cost-sharing reductions or the ACA’s limits on out-of-pocket costs\textsuperscript{xlvi} (which for 2014 were $6,350 for an individual and $12,700 for a family). Although CMS indicated in the preamble to the proposed regulations that the agency was considering an exception for out-of-network costs where in-network services are unavailable to the enrollee, the agency declined to so provide in the final regulations in recognition of the “historical flexibility and responsibility given to State in this area.”\textsuperscript{xlvii} At the state level, and pre-dating the ACA, several states (including Colorado, Missouri, and Montana) required issuers that did not have an in-network provider to meet a patient’s needs to allow the patient to obtain care out-of-network at the in-network cost-sharing level.

As implemented, network adequacy standards under federal rules give states considerable flexibility in interpreting what would constitute “sufficient” numbers and types of
providers that can deliver covered benefits without “unreasonable delay.” In Federally Facilitated Marketplaces where federal regulators are responsible for health plan certification, states are still responsible for reviewing network adequacy as part of the certification process if the state’s authority to review plan networks under a network adequacy standard is at least consistent with Federal standards. Federal regulators may conduct network reviews themselves in these states, rather than simply accepting state reviews or accreditation status.\textsuperscript{xlviii}

In conducting its reviews of network adequacy, the Center for Consumer Information and Insurance Oversight (CCIIO) has told issuers it will “focus most closely on those areas which have historically raised network adequacy concerns,” including hospitals and mental health, oncology, and primary care. Federal officials have intimated that they may, in the future, develop new, quantitative limits on the length of time or distance required for an enrollee to access benefits.\textsuperscript{xlix}

A pressing need exists for state insurance authorities to continuously monitor the adequacy of issuers’ networks. In doing so, policymakers must balance the interests of consumers and provider stakeholders in having a broad choice of in-network providers against consumers’ equally important interest in affordable costs.

\textbf{Any Willing Provider Laws}

In response to the consumer and provider backlash against the tightly managed care networks that proliferated in the 1990s, some states enacted laws intended to restrict the ability of managed care issuers to selectively contract with providers. These state laws are termed “any willing provider” (AWP) laws. AWP laws generally require issuers to accept into their network any provider willing to comply with the issuer’s rates, terms, and conditions. Some AWP laws only require health plans to negotiate with all providers, without requiring the plans to contract with all providers seeking network inclusion. According to one count, 28 states have an AWP law in place, though the specifics vary considerably from state to state; some are limited to specific providers, most frequently pharmacy providers, while others apply to all providers.\textsuperscript{lv}

\textbf{VI. State Network Adequacy Standards: Quantitative vs. Subjective Approaches}

Establishing a standard for network adequacy—or for what it means for an issuer to provide reasonable access to health care services—is no simple matter. Either a quantitative or subjective approach may be taken. States regulating the adequacy of commercial issuers’ networks under a quantitative approach set standards such as time and distance limits, provider-to-enrollee ratios, and appointment waiting-time limits.\textsuperscript{li} For example, California’s Department of Managed Care sets out maximum travel times and distances, maximum wait times, and minimum provider-to-enrollee ratios.\textsuperscript{lii} while Texas caps an HMO policyholder’s travel at no more than 30 miles in non-rural areas and 60 miles in rural areas for primary care, and 75 miles for specialty care and specialty
hospitals. Twenty-nine states have set such standards for their Medicaid managed care organizations.

Other states impose more subjective or flexible standards for commercial plans, similar to the reasonable access standard in the NAIC model law and federal regulations. For example, Colorado requires managed care plans to demonstrate that their network is “sufficient” to provide access “without unreasonable delay,” and allows issuers to set provider-enrollee ratios according to “reasonable criteria.”

Whether quantitative or subjective, when states have standards for commercial health plans, most are directed toward health maintenance organizations and not other network-based plans, such as preferred provider organizations.

At the federal law, the Medicare program has established the following quantitative network standards for participating MCOs in the Medicare Advantage program:

- minimum enrollee-to-provider ratio;
- maximum travel times to the closest provider;
- maximum distances to a provider; and
- average number of enrollees in service areas.

Setting clear quantitative standards and conducting an up-front review of plans’ networks to determine whether they meet those standards has advantages and disadvantages. Among the advantages are the clarity and certainty of numerical standards, and a level playing field among issuers, who, if given flexibility to define adequacy would likely do so differently. Quantitative network adequacy standards have drawbacks, but they currently offer the most effective way to hold issuers accountable to a common standard, build confidence that Marketplace plans are high quality, and help ensure that consumers receive needed care within a reasonable proximity to their home or place of work.

However, this type of regulation is not without issues. First, because networks evolve over time as clinicians and hospitals are added or dropped from the network, the network adequacy review process provides only a temporary snapshot—and may tell a consumer little about the plan at the point in time he or she is purchasing it. Second, it may be difficult to set a standard that sufficiently accounts for demographic, geographic, and market variables across the state. Third, there is currently only limited actuarial data for enrollees in Marketplace plans, particularly enrollees previously uninsured. It is not yet fully understood how they are seeking and receiving care. An approach to network adequacy that has worked well for a population with a stable source of employer-based coverage and care may be insufficient for the population of people enrolled in Marketplace plans. Fourth, and more pragmatically, many state insurance regulators lack the capacity to conduct a comprehensive, annual review of issuers’ provider lists and contracts across all their plan offerings.

With greater transparency, better consumer information, and robust market oversight, over time quantitative standards, given their many limitations, may prove to be unnecessary. Instead of quantitative standards, many states may prefer to give issuers
more flexibility to tailor their networks by taking a subjective approach. However, a subjective standard—such as ensuring policyholders can receive services without “unreasonable delay”—could eventually leave the determination of reasonableness in the hands of the courts and out of the state’s control.

VII. Protecting Access While Preserving Flexibility

Whether or not a state adopts a quantitative or subjective regulatory approach to its oversight of QHP networks, no state should consider its oversight job complete after an issuer’s plan is approved. In addition to reviewing the overall number and distribution of in-network providers, state officials need to consider consumers’ ability to understand what kind of plan they are purchasing and, once purchased, their ability to obtain in-network care. Under the regulations adopted to implement the ACA, federal and state regulators have new authority to collect data from issuers on the volume and types of services enrollees are receiving out-of-network. While capacity to collect and analyze that data may be limited initially, regulators should, over time, be able to identify outliers or trends suggesting a lack of network adequacy.

State and federal regulators can be closely monitoring and publishing on state websites plans’ consumer satisfaction scores, such as those collected via the Consumer Assessment of Healthcare Provider and Systems (CAHPS) survey, as well as complaints received by issuers, the Department of Insurance, and the Marketplace. They can also be conducting “secret shopper” surveys to assess whether policyholders can actually obtain necessary care within the network on a timely basis and within a reasonable geographic radius of their home or workplace. In addition, data can be made available to health researchers, whose published studies can supplement analyses by state agencies.

Quality of Access

The National Committee for Quality Assurance (NCQA) has observed that “Current network adequacy standards put a premium on the number of providers in a plan’s network. They rarely address whether those in-network providers are high quality or offer expanded access.” To ensure that the access provided is quality access, state regulators may want to consider asking whether providers in the network are reimbursed or receive incentives when they use information technology such as videoconferencing, email, live chat, and electronic health records to communicate with and deliver care to patients. Reviewers might also want to examine whether the issuer is using reimbursement or cost-sharing incentives to encourage providers and patients to use the most appropriate care setting for the care being delivered.

Using a Flexible Standard to Define the Network

And while state and federal regulators have not historically included metrics on access that reflect the changing nature of care delivery, effective regulation needs to be flexible enough to accommodate new and emerging delivery models. Regulators should have the flexibility to grant issuers waivers if they can demonstrate that hospitals and specialty
providers not located within the requisite geographic area meet a plan’s expectations for price and quality performance. With such flexibility, providers outside the network who use telemedicine, offer evening and weekend office hours, and serve as Centers of Excellence for specialized care could be considered, or even preferred.

At a minimum, issuers who do not have an in-network hospital or clinician to perform a needed service, or do not have a provider with the appropriate training and expertise, should be required to provide coverage for that service out-of-network at no additional cost to the policyholder. Such a requirement helps ensure that consumers are held harmless if the care they need is only available out-of-network. This requirement, accompanied by advance disclosure, can also help consumers who might face unexpected balance billing when they receive care at an in-network facility from an out-of-network provider.

A 2014 New York law holding patients harmless for surprise bills when at in-network facilities, while not effective until April 1, 2015, could become a model for other states. The law’s transparency provisions force insurers to make network status clear online, keep provider directories up to date, provide comparison rates and tell patients which doctors involved with an upcoming procedure are in-network. Doctors have to disclose their status on request and let patients know in advance about anticipated charges. Hospitals have to disclose price information on their website and whether a doctor is a hospital employee or operating independently.

VIII. Use of New Platforms Can Aid in Building Network Adequacy

Traditional network adequacy time and distance standards, such as those utilized for Medicaid and Medicare managed care programs, are usually tied to the fee-for-service, visit-based model of care. For many services that model is changing. In today’s digital age, technological approaches must be adopted to improve provider networks and accommodate the needs of consumers and providers. Network adequacy standards should reflect the value-based models of care being adopted and mandated across multiple care continuums.

Telemedicine permits examinations to be conducted by remote monitoring and videoconferencing technologies, to bring care to remote areas where provider networks have heretofore not sufficed and permitting care to be moved from institutional to home- and community-based settings. Medicare and other payers are supporting team-based care to improve communication, reduce unnecessary services, and improve both access and quality. Urgent care centers and minute clinics are providing high-quality, easy-to-access care. Other new initiatives are building high-quality specialty care expertise (or making specialty care accessible) in rural primary-care practices.

Integrating Care within Narrow Networks
Limited networks can support integration in delivery through the offering of clinically integrated care systems that can be especially helpful for those with chronic diseases. In these tighter networks, providers should be able to communicate more openly and easily, sharing information on common electronic health record platforms about patients’ conditions. Payers and providers can share more meaningful mental health and health care data, working together using common health care analytics to determine appropriate improvements for achieving quality outcomes and cost reductions.

This structure can also reduce duplicate testing and even conflicting treatment regimens. Providers within a clinically integrated network tend to be more familiar with each other’s medical practice protocols and administrative practices, enhancing continuing of care by allowing patient handoffs to be made more smoothly with less error. And these tighter relationships create greater leverage for providers in negotiating improvements to the payment system.

**IX. Consumer Education, Protection, and Transparency**

Even with these improvement opportunities, there still must be adequate consumer protection and education, particularly for those families accessing the new health insurance products offered through the Marketplaces. To qualify for a subsidy in the Marketplace, a purchaser must have a family income of between 100 percent FPL ($11,490 for an individual; $23,850 for a family of four) and 400 percent FPL ($45,960 for an individual; $95,400 for a family of four). Eighty-three percent of individuals purchasing products on the Marketplaces qualified for an insurance premium subsidy.\(^{lx}\)

A large percentage of Marketplace enrollees—as many as 57 percent—have not been insured previously.\(^{lx}\)

**Improving Transparency**

All consumers need the ability to make an informed choice both inside and outside the Marketplaces. It is important for patients and families to understand their networks when they sign up for the health plans. They need to know they will face deductibles, large premiums, and co-pays or co-insurance, and possibly that their family provider may not be covered at all. Consumers cannot be expected to make optimal choices about plans and providers if they cannot get easy-to-understand, up-to-date, clear information about the type of plan network they are buying and the names, locations, and types of participating providers. At a minimum, consumers need standardized information about the breadth and restrictiveness of plan networks before they make a purchasing decision. Consumers would also benefit from plan performance rankings through consumer satisfaction scores or a star-rating system similar to that utilized in rating Medicare Advantage plans.

It is very important for consumers to understand the network features of a plan during the shopping process and how those features would apply to care provided by specific providers. If an issuer maintains multiple networks, it should be made clear to consumers at enrollment which provider network a given plan makes use of. Similarly, practitioners
should have a clear understanding of which networks they are members of in order to prevent confusion and unexpected balance billing of consumers.

Issuers need to be more accountable in educating their customers on their products, not just on who is in their networks, but also on related cost-sharing and trade-offs made when choosing a low-coverage, low-premium product. This educational process is especially important for the newly-insured who lack previous experience with insurance and are likely have some cultural and language barriers to understanding.

The ACA requires that plans sold on the Marketplaces include a provider directory and denote when a listed provider is not accepting new patients. However, in the first year of implementation, with many other technology challenges confronting them, the Marketplaces did not provide that information to consumers in an actionable way. Online provider directories are often incomplete, outdated, or inaccurate. Hard copies of directories may be hard to find. It’s also not unusual in a community for several practices or providers to have a similarity of names that can add to consumer confusion.

Finally, access to practice hours and information on the provider’s capacity to accept new patients is important. An individual enrolling on www.healthcare.gov must leave that website and go to the various issuers’ or providers’ websites to determine more about network providers, information that should instead be easily accessible through links on the www.healthcare.gov website.

At present under federal regulations, enrollees in Marketplace plans may take advantage of Special Enrollment Periods (SEPs) to change their plans when there is a change in the enrollee’s life circumstances or when either of the following circumstances occur:

- the individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Marketplace or HHS, or its instrumentalities as evaluated and determined by the Marketplace; or
- the enrollee adequately demonstrates to the Marketplace that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.

At a minimum, Marketplace officials should offer a consumer an SEP to switch plans or issuers when he or she was given inadequate or incorrect network information when making an initial plan selection.

Current practice allows an issuer or health plan to develop quality metrics of their choosing. Sometimes these measures are similar or the same as those used in Medicare and Medicaid, but not always. The development of a consistent set of quality measures and standards is critically important to determining whether provider networks are adequate. A defined, uniform set of outcome-based measurements used across all Marketplace plans could provide consumers with more understandable and meaningful information for comparing the quality of providers within their communities.
As HHS and NAIC are working to further define network adequacy, there are some key considerations that need to be kept in mind:

- First, the individual Marketplace includes many medically vulnerable families who are also low-income. Measuring the distance to providers is sometimes not simplistically solved by measuring miles. A distance of 30 miles to a hospital may not seem far, unless you lack a means of personal transportation and rely solely on public transportation.

- Low-income individuals purchasing coverage in the Marketplace may have complex child-care needs requiring access to providers’ after normal business hours.

- The ACA established affordability standards for health premiums, but the cost-sharing subsidies for those with lower incomes still leave large out-of-pocket medical expenses that can be unaffordable for low-income enrollees.

- High deductible plans with significant out-of-pocket costs can force enrollees to delay or self-limit their access to care. This in turn reduces continuity and consistency of care and non-adherence to treatment regimens. Coordination of care becomes difficult.

**X. Factors to Consider in Regulating Provider Network Adequacy**

The primary objective of network adequacy regulation, of course, is to ensure that if an issuer requires enrollees to receive benefits from in-network providers, or provides financial incentives to do so, the network is capable of providing those benefits to enrollees when needed. This includes looking at the availability of hospitals, primary care and specialty providers, and pharmacies to ensure that networks have enough providers throughout their service area to provide benefits, as well as the issuer’s procedures for remedying any provider shortages in the service area and allowing out-of-network care when warranted.

This analysis should, however, take into account a number of important factors in order to confirm that the standards put in place to fully ensure access to care are achievable by issuers. These factors include:

- **General provider availability in a given geographic area.** Consideration should be given to the number and types of providers and facilities located in a given area. General availability will vary depending on population, urban density, and the willingness of local providers to enter into contracts under reasonable terms and conditions. As part of the network analysis, a state’s specific geographic makeup may require modifying network adequacy standards. Geographical barriers—such as mountain ranges and bodies of water—may exist that impede timely access to care. Any analysis of accessibility should be based on more than
a simple mileage-based calculation. Regulators must meet that challenge by proposing rules that provide the most logistical and reasonable method to ensure the population living in remote areas has in-network access to the type of healthcare they need.

- **Medical care referral patterns and hospital admission privileges.** Network analysis should include a review of the hospital admission privileges of providers as well as typical referral patterns for the service area. This information may be obtained from the state health department; hospital admission privileges are typically gathered as part of the issuer’s provider credentialing process. Analysis must confirm that providers requiring the use of facilities—including hospitals, ambulatory surgical centers, and specialty treatment facilities—are able to admit their patients to network facilities.

- **Availability of hospital-based providers.** Hospital-based providers—such as radiologists, pathologists and emergency room physicians—may not be part of the same network as the facility, or in any network. This is particularly the case if the hospital’s providers are contracted exclusively with the facility. Historically, ensuring adequate insurance coverage of these providers has been a challenge, as there is often little incentive for them to contract with issuers. Most patients do not specifically choose the radiologist reading their imaging test or the pathologist conducting the biopsy on their tissue samples.

- **Willingness of providers to contract with issuers.** State insurance regulators may need to take “provider willingness to contract” into consideration when developing network adequacy rules. Historically, certain categories of specialists have refused to contract with issuers, especially in parts of the country where there are shortages.

- **Location and availability of ECPs.** The location and availability of ECPs, particularly mental health and substance use treatment providers, is not specifically addressed in most existing state laws. However, the final Marketplace rule specifically requires networks to include an adequate number of these providers. As noted previously, federal guidance for 2015 requires Marketplace issuers to cover at least 30 percent of ECPs available in the issuer’s service area, to serve the low-income and medically underserved population. The QHP must provide a list of ECPs included in each of the proposed networks, including provider name, street address, associated issuer network ID number, and National Provider Identifier (NPI), if available.

- **Centers of Excellence.** The availability and access to Centers of Excellence for transplants and other medically intensive services is crucial, as is the availability of critical care services such as advance trauma centers and burn units, etc. If an issuer does not have such providers in their networks, arrangements must be made by the QHP issuer to ensure access to these specialized services.

- **Availability for new patients.** The capacity of provider types to accept new patients is a critical component of understanding the network. It is also imperative
to recognize that different QHPs may include the same provider or facility, reducing that provider’s patient capacity.

- **Paraprofessionals and peer support.** Particularly in the behavioral health field, where professional providers are becoming scarcer, consumer have come to be increasingly reliant on peer support services. Any consideration of network adequacy must take into account the availability of such recognized non-professional providers. Similarly, where state scope of practice laws permit, networks should factor into adequacy standards access to paraprofessionals such as advance practice nurses and physician assistants.

Overly rigid network adequacy requirements can lead to premium increases, as issuers lose the ability to meaningfully negotiate with providers over the price of delivered items and services. By entering into a network agreement with an issuer, providers strike a bargain, accepting lower reimbursement in Marketplace for the higher volume of patients seeking in-network care. Narrower networks sharpen this bargain even further, but the issuer’s pool of patients is spread over a smaller number of participating providers. According to one industry analysis of broad- and narrow- network QHPs, premiums for broad-network plans were 5 to 20 percent higher.\(^{lxiv}\) And as noted earlier, a McKinsey analysis of QHPs with narrow hospital networks found premiums reduced for those plans with the narrower networks by 26 percent.\(^{lxv}\) For this reason, it is important for regulators to be mindful of the premium impact of requiring issuers to maintain broader networks, especially if a narrower one can still provide sufficient access to all promised services.

**XI. Recommendations of the Coalition for Whole Health on Network Adequacy**

The Coalition for Whole Health (CWH) is an alliance of advocacy organizations representing consumers and providers in the MH and SUD treatment fields. CWH has issued recommendations for minimum MH and SUD services network adequacy requirements for QHP certification and ongoing operations.\(^{lxxvi}\) The Coalition’s recommended messages to state policy makers include the admonition that “networks should be sufficient in number, mix, and geographic distribution of providers to ensure access to all covered MH and SUD services in a timely manner that is not detrimental to the health or well-being of the enrollee.”

CWH says that, at a minimum, QHPs should be required to meet network adequacy standards related to:

- enrollee-to-provider and enrollee-to-staff ratios (reflecting administrative and support staff ratios as well as professional and specialty provider staff ratios), ensuring that a sufficient number of MH and SUD providers licensed or certified by the state are available to consumers to ensure adequate choice;
- timely access to providers to address MH and SUD needs within 24 hours for urgent care and within 10 to 14 calendar days for routine care;
• access, for consumers in need of more comprehensive, coordinated care, to providers that offer a full range of whole-person services;

• travel time and distance to providers, which should take into consideration logistical barriers, such as a lack of accessibility by public transportation, that are not addressed by simple mileage and travel-time criteria;

• appointment waiting times, hours of operation, emergency service availability when medically necessary, and provider acceptance of new patients for transitional care, preventive care, non-urgent care, and emergency care;

• reasonable proximity of at least two network MH providers and at least two network SUD providers to the business or personal residence of covered consumers for each point along the continuum for consumer conditions, and for at least 90 percent of plan enrollees; and

• access to out-of-network providers at no additional cost to the enrollee when network providers cannot be made available.

**Ongoing Monitoring of Network Adequacy**

CWH warns that, to ensure plans meet the minimum standards for network adequacy on a consistent basis, each QHP should have in place a system for monitoring its network and procedures and to react to impending and ongoing changes in its network that may impair network adequacy. QHPs must be required to demonstrate on an initial and ongoing basis to regulators that they have sufficient capacity to meet the full continuum of MH and SUD needs for the expected enrollment in the service area, reflective of emerging technologies and new models of care and reimbursement.

CWH also recommends the adoption of in-network cost-sharing levels for out-of-network care; implementation of nondiscrimination provisions to ensure consumers have access to health care that is culturally and linguistically appropriate; protections designed to eliminate adverse selection of members by plans; and the development of data collection systems to evaluate provider networks and monitor the compliance of health plans with network adequacy standards.

CWH says that all plans should be required to undergo an annual state review of network adequacy that includes:

• anticipated enrollment;

• expected utilization of services;

• numbers and types of providers required to furnish the services;

• existing total, unduplicated number of MH and SUD service providers in the network;

• numbers of network providers not accepting new patients;
• geographic location of providers and plan enrollees, considering distance, travel time, the means of transportation used by enrollees, and physical access for enrollees with disabilities;
• the plan’s process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the MH and SUD needs of its enrolled population; and
• identification of any direct or indirect barriers to access.

Further, CWH says a plan should be required to demonstrate that it monitors, on an ongoing basis, the ability, clinical capacity, financial capacity, and legal authority of its providers to furnish all contracted benefits to covered persons. If access is going to be unavailable, the QHP should be required to make arrangements acceptable to the state insurance commissioner or department, the Marketplace board, federal regulators, or other regulating entities that the out-of-network services are provided at no greater out-of-pocket cost to the enrollee.

CWH suggests that states may also want to consider requiring issuers to assess and report enrollee satisfaction with the plan’s network of MH and SUD providers, using measures applied uniformly by all issuers offering QHPs in the Marketplace. To ensure consumers can make informed choices of plans, this information should be made available to consumers electronically, with access to hard copies, during open enrollment.

CWH contends issuers should be required to submit for state regulatory review the provider and intermediary contracts used to create and maintain QHP networks of MH and SUD providers. Issuers should have to demonstrate to regulators during review that:

• the issuer’s standards for selecting providers does not permit the issuer to avoid signing providers simply because those providers serve potentially higher-risk populations with a risk of higher than average claims, losses, or service utilization; and
• the issuer does not penalize a provider who reports in good faith to state or federal authorities any act or practice by the issuer that jeopardizes patient welfare.

CWH also suggests that issuers be required to demonstrate a minimal overlap between their QHP network of providers and their Medicaid managed care networks of providers if they serve both Marketplace consumers and Medicaid enrollees.

**Compliance and Sanctions**

CWH recommends that there be a formal enforcement policy in place for issuers that do not maintain an adequate network of MH and SUD providers. Depending on the type and degree of violation, CWH says enforcement could include:

• affording the issuer a notice and opportunity to correct;
• civil penalties;
• restricting the plan’s service area;
• precluding a plan from selling new policies; or
• revocation or suspension of the plan’s QHP certification or license.

XII. Recommendations: Policy Options for States

A full analysis of the implications of strategies for aligning provider networks is beyond the scope of this paper, however, some options for states are suggested below.

Dual Certification of Plans and/or Providers

Individuals churning between Medicaid and the Marketplace would benefit from joint development of a common framework for managed care plan certification. The certification could be in such areas as consumer information, clinical quality measures, provider network composition and capabilities, and access. State Medicaid staff have developed a wealth of expertise and experience in MCO purchasing strategies, which can inform QHP certification.

State Medicaid policies provide models of contracting requirements designed to ensure provider continuity of care as eligibility status changes, particularly for individuals undergoing treatment for acute or chronic medical conditions. Consultation between Medicaid and the Marketplace would enable the Marketplace to consider network requirements for certification that promote continuity of care for individuals likely to move between types of coverage, over and above the ACA minimum network adequacy requirement for QHPs that requires inclusion of behavioral health providers and ECPs. States should also consider providing incentives to, or mandating, issuers to participate in both the state Medicaid program and the Marketplace.

Increase Provider Incentives to Participate in Medicaid

Of course, the availability of a consistent set of providers across Medicaid and QHPs will also depend on provider rate sensitivity. Research shows that reimbursement is the most important factor in providers’ decisions to participate. Low Medicaid reimbursement rates are widely blamed for low provider participation in the program. The ACA mandated that states implement a temporary increase in rates in 2013 and 2014 for physician providers of primary care services with a specialty designation of family medicine, general internal medicine, or pediatric medicine, an increase that has been paid for at a 100 percent federal match rate. Although that enhanced federal match will no longer exist in 2015 and beyond absent Congressional action, states may want to maintain those increases beyond the ACA’s two-year pilot, with CMS State Plan Amendment approval, and receive the state’s traditional federal match for the higher reimbursement.

States also can take the alternative approach of requiring providers who are in QHP networks for issuers that participate in both the Marketplace and Medicaid to contract to participate in both the commercial and Medicaid products of that issuer. Either approach
would increase access to primary care providers and specialists and result in improved continuity of care for enrollees.

**Require Issuers to Contract with Any Willing ECP**

Although health reform in Massachusetts significantly improved levels of coverage, many lower-income individuals who were previously uninsured chose not to switch their site of care once they gained coverage. In fact, between Calendar Years 2005 and 2009, the number of consumers receiving care at Massachusetts community health centers increased by 31 percent. These consumers reported that they preferred the “safety net” facilities they had been using, and that they used these facilities because they were convenient (79.3 percent) and affordable (73.8 percent). Safety-net patients did not view the facilities as providers of last resort; rather, only 25.2 percent reported having had problems getting appointments elsewhere.\textsuperscript{xviii}

To the extent possible, and to encourage not only network adequacy but also continuity of care, consumer relationships with existing willing safety net providers should be retained if that is the wish of the consumer. Requiring issuers to contract with any willing ECP would serve to further this goal.

**Emphasize Provider Quality**

Current network adequacy standards put a premium on the number of providers in a plan’s network. They rarely address whether those in-network providers provide high-quality services or offer expanded services. This can make it difficult for plans to develop products with smaller networks that promote access to high-quality, low-cost providers, while limiting access to poor-quality, high-cost providers.

In addition, although ACA regulations require that issuers submit copies of their provider directories to the Marketplaces and to potential enrollees—in hard copy on request—and identify whether those providers are taking new patients, provider plans can change. The provider may fail to notify the impacted issuer in a timely manner, so that the QHP can notify its impacted members. This complicates efforts by QHPs and Marketplaces to help consumers find providers.

NASMHPD advocates flexible network adequacy standards that support innovation while closely monitoring patient experience—and taking action to work with plans to address access problems as they arise. The following steps should be considered for ensuring provider access and quality and continuity of care:

- **Focus on the beneficiary**: No matter what state network adequacy standards are put in place, compliance with those standards must be continuously monitored. Marketplaces need to work with stakeholders to determine how frequently provider directories need to be updated and how this might be incorporated into evaluating network adequacy. Monitoring plan performance using survey results from the CAHPS can serve as an important way to gauge whether plans are
providing timely and adequate access. Using CAHPS also allows Marketplaces to compare the performance of plans across product lines to understand whether problems are broadly experienced or are a reflection of a particular issuer’s network(s). CAHPS surveys can also shed light on how Marketplace QHPs compare to Medicaid plans.

- **Care coordination**: Payers are expanding support for care coordination between providers and facilities so patients don’t fall through the cracks when moving between care settings. In 2015, Medicare will begin paying primary care providers to provide chronic care management services to beneficiaries when they transition out of the hospital.\textsuperscript{lxix} Care coordination can be an important tool for consumers in ensuring access to critical providers.

- **Use of e-technology and telemedicine.** Many QHPs are exploring ways to support care delivered outside of face-to-face visits, encouraging providers to communicate with patients by phone, text, and email. Providers as well have started using electronic medical records with online portals that enable patients to easily look up and share their health information. Similarly, hospitals are embracing electronic Intensive Care Units (eICUs), continuously monitored and treated by intensivists, who are subspecialty-trained ICU physicians. Research indicates that ICU patients managed by intensivists do better than patients managed by providers without that training. However, intensivists are in short supply, especially in rural areas. eICUs bring the intensivists’ expertise to rural intensive care units via video-monitoring technology.

The intensivist-led eICU team works in a central location to provide expert care when the primary or consultant physicians are not at the patient's bedside. Through a network of cameras, monitors, alerts, and two-way communication links, doctors and critical care nurses at the eICU command center make virtual rounds of patients. Intensivists can monitor the condition of patients, check vital signs, X-ray, and laboratory data, and communicate with physicians, hospital staff, patients or family members. One recent study found that intensivists working with eICU patients reduce both mortality and length of stay.\textsuperscript{lxx}

- **“Skyping” therapists**: Web-based counseling is filling critical gaps in mental health care. HealthLinkNow, operating in Montana and Wyoming, in June 2012 received a three-year, $7.7-million CMS Health Care Innovation Award to provide tele-psychiatry services in underserved areas in the two states.\textsuperscript{lxxi} Kansas Medicaid authorizes reimbursement for telehealth and requires MCOs to establish a telemedicine program for substance use disorders.\textsuperscript{lxxii} Even outside rural areas, mental health counselors and other providers are opening up more convenient web-based practices.

Since 2006, the Federal Communications Commission (FCC) has led the Rural Health Care Pilot Program. The program funds projects that spread Internet access and use telemedicine to connect rural providers with providers and consumers in urban areas. In South Carolina, the Palmetto State Providers Network reported its tele-psychiatry program has made psychiatric consults available 24/7 and saved South Carolina Medicaid $18 million dollars.\textsuperscript{lxxiv}
• **Spreading specialist expertise:** Project ECHO (Extension for Community Healthcare Outcomes), a University of New Mexico School of Medicine initiative with funding from the Robert Wood Johnson Foundation, connects urban specialists with rural general practitioners, using telemedicine to co-manage complex patients. Over time, the general practitioners develop expertise to manage the complex patients on their own. A New Mexico Medicaid managed care plan, Molina, is now providing video-conferencing specialty care consults to primary care providers on complex medical conditions through Project ECHO.\textsuperscript{lxv}

In another vote of confidence, the Department of Veterans Affairs recently launched a major pilot to broaden access to specialty pain-care management using the ECHO model.\textsuperscript{lxvi}

• **Value-based purchasing:** Value-based purchasing encourages the use of high-value providers and facilities. They also discourage using poor-quality providers and services shown to be ineffective. Requiring issuers to provide services through health homes or accountable care organizations, or basing bundled reimbursement on episodes of care, so that providers must communicate with each other in order to access shared reimbursement from coordinating team leaders, ensures that the providers themselves will be working together to facilitate ready and timely access by consumers to other providers on the team. Embracing team-based care will not only help improve access, it should lower costs and improve quality.

**XIII. Other Suggestions for Developing Marketplace Network Adequacy Requirements**

Regulators, plans, and other stakeholders should consider the following additional suggestions as they look for ways to evolve network adequacy assessments.

• Requiring Medicaid managed care plans to have in-office wait-time standards in their provider contracts is still important to addressing disparities in treatment.

• The influx of newly insured patients in 2014 has put pressure on the already-stressed primary care and adolescent mental health infrastructure. Marketplaces can work with issuers and legislatures to address provider shortages through revisions to scope-of-practice rules, in order to facilitate access to paraprofessionals such as advance practice nurses and physician assistants.

• Over the last several years, states facing budget shortfalls have reduced agency staffing to cut costs. This may impact their ability to effectively monitor plan compliance with network adequacy standards. Requiring QHPs to rely on review and certification by NCQA, URAC, the Joint Commission or other similar national organizations may be an option for states with resource constraints. Although these organizations do not currently review whether plans include ECPs in their networks, at least NCAQ has stated this could be included in future updates to the organization’s health plan accreditation procedures.
Conclusion

Marketplaces and other plan regulators have a challenging opportunity to explore possible ways to modernize network adequacy requirements. The ACA’s broad network adequacy standards, provider workforce shortages, evolving technology, delivery system reforms, and expanded coverage through Marketplaces create an important crossroads for states to rethink network standards in ways that not only ensure and improve access, but also enhance quality, ensure affordability, and afford consumer protections.

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1 42 U.S.C § 18031(c)(1)(B).
2 The State Health Reform Assistance Network (August 2013). ACA Implications for State Network Adequacy Standards.  
http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407486
3 45 C.F.R. § 156.230(a)(2)
4 Essential Community Providers are those eligible to receive discounts under the 340B program, as mandated under § 340B(a)(4) of the Public Health Service Act. The list includes FQHCs, safety net (high Medicare Disproportionate Share) hospitals, critical access hospitals, sole community hospitals, and children’s hospitals, hemophilia treatment centers, rural referral centers, Ryan White HIV/AIDS clinics, and other specific entities.
5 § 1311(c)(1) of the Patient Protection and Affordable Care Act, codified at 42 U.S.C § 18031(c)(1).
6 76 Federal Register 41866, 41893-4, 41921. (July 15, 2011).
7 Ibid.
8 Ibid, 18420.
9 77 Federal Register 18310, 18409, 45 C.F.R. 155.1050, 156.230 (March 27, 2012).
10 Ibid, 18421, 45 CFR. 155.235(a).
11 Ibid, 18419.
13 77 Federal Register 18310.
16 Ibid, 18470, 45 C.F.R. 155.235(b).
17 45 C.F.R. 156.230(b).
19 77 Federal Register 18328.
20 45 C.F.R. 156.235(a).
21 77 Federal Register 18421.
22 77 Federal Register 18422.
23 Ibid.
26 Managed Care Plan Network Adequacy Model Act, Sec. 5, National Association of Insurance Commissioners (October 1996).


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