



Network Adequacy Checklist

Public discourse on network adequacy primarily focuses on the ability of a health plan to provide enrollees with timely access to a sufficient number of in-network providers who provide health care services included in the benefit contract. However, consumers win when the providers included in the network are also held to high standards of quality. Therefore, it is important that health plans consider not only provider costs but also the quality of their services when making decisions about network inclusion. Additionally, provider networks need to be transparent so consumers can make informed decisions in choosing a health plan.

The following checklist is to support consumer advocates in their work advocating for robust network adequacy standards at the state level and can be used as a guide for discussions with state policymakers and coalition partners. The specific avenues of advocacy and policy issues within network adequacy depend heavily on state environments and resources. However, given that provider networks have [far-reaching implications](#) for consumers, we suggest the following [five principles](#) – *sufficient choice of providers, timely access, affordability, quality and transparency* – to unite consumer groups in their advocacy for network adequacy standards that ensure affordable access to the highest quality providers.

Sufficient Choice of Providers

Health plans should include a wide range of providers to deliver all health care services included in the plan's benefit package.

- Do health plans include a sufficient number of primary care providers (PCPs) in-network for each of the following categories: family physicians and practitioners, general physicians and practitioners, internists and pediatricians?
- Do health plans include an adequate number of specialists in-network for each specialty covered (including but not limited to the following: hospital systems, mental health providers, oncology providers, dental providers, providers specialized in LGBT health, women's health, mental health and substance use disorders services, cancer treatment, HIV/AIDS, diabetes, etc.)?
- Do health plans include a full range of pediatric providers including pediatric subspecialists, pediatric dental providers and providers that provide care to children with special needs?

ACA §1311(c)(1)(A)(B); 45 CFR §156.230

- *Health plans are required to maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorders.*

Final Notice of Benefit and Payment Parameters 2016

- *Out-of-network providers cannot be counted for purposes of meeting network adequacy requirements.*

- Do health plans include providers that provide ancillary services such as diagnostic services, home health services, physical therapy, speech therapy and occupational therapy?

□ ***Inclusion of essential community providers (ECPs)***

- Do health plans have a sufficient number of ECPs to provide care for low-income and medically underserved consumers?
- Do health plans include an adequate number of ECPs in each [ECP category and type](#), including: 1) substance use disorders treatment and recovery service providers and community mental health providers; 2) pediatric dental providers; and 3) essential pediatric community providers?

ACA §1311(c)(1)(C); 45 CFR §156.235.

- *Plans must maintain 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 plan’s service area.”*
- *Plans must include 30 percent of available ECPs in the plans’ service area.*

[2016 Letter to Issuers \(Table 2.1\):](#)

- *Plans must include specific ECP provider types in each ECP category.*

Note: It is important that qualified health plans (QHPs) maintain a sufficient number of ECPs with experience providing quality care to consumers from diverse backgrounds and low-income families with the greatest health needs. ECP inclusion is especially crucial in states (such as Arkansas, Iowa and Pennsylvania) that will use Medicaid funds as premium assistance to purchase coverage in the marketplace for individuals with income at 100 percent of the federal poverty level or lower. Additionally, consumer advocates should continue to [advocate for a higher threshold](#) than the federal requirement (30 percent of available ECPs in the plans’ service area) because, in a geographically large rural county, one health center located in a corner of the county may not be accessible for those who reside on the other side of the county. Low standards on ECP inclusion will fail to ensure reasonable and timely access to needed care for low-income and medically underserved individuals.

□ ***Non-discriminatory network design***

- Do health plans include provider facilities that ensure accessibility for consumers with disabilities by complying with the ADA?
- Do health plans measure access based on providers in the lowest cost-sharing tier for every covered service? People with chronic illnesses often face discrimination due to the high cost of treatment. Insurers might exclude or classify high cost treatment providers (such as cancer treatment centers) at a high cost sharing-tier as a way to exclude patients.
- Do health plans offer networks with a sufficient number of culturally and linguistically competent providers?
- Are language access services available including American Sign Language and Braille?

ACA §1303, §1312, §1557 and §2706

Health plans are required to comply with the Americans with Disabilities Act (ADA), the Mental Health Parity and Addition Equity Act, and other federal laws on non-discrimination including Title IV of the Civil Rights Act of 1964 and Section 1557 of the ACA.

- Do health plans design provider networks in a way that discriminates against consumers due to their health status, race, gender, sexual orientation, disability, immigration status or age? For example, do they exclude providers who have experience providing care for the LGBT population?
- Do health plans offer networks with a sufficient number and diversity of providers to deliver all health care services included in the plan's benefit package?

Timely Access

□ Timely access to all covered benefits

- Do health plans include clear quantitative access standards that ensure timely access to care for consumers?
 - How long is the wait time for appointments?
 - How far is the travel to providers?
 - How long is the office wait time?
 - Can consumers access providers by the telephone 24 hours a day, seven days a week?
 - Can consumers make appointments during non-typical office hours including after 5 p.m. and on the weekend?
- Do consumers have immediate access to life-threatening emergency care including care for substance use and mental health emergencies, and emergency access to child-specific emergency services and specialists?

ACA §1311(c)(1)(B); 45 CFR §156.230

- *Health plans are required to ensure all services will be accessible without unreasonable delay.*

2017 Letter to Issuers in the Federally-Facilitated Marketplaces

- *CMS will review QHPs' network adequacy using quantifiable time and distance metrics detailed in its 2017 Letter to Issuers. The review will focus on the following specialties: hospital systems, dental providers (if applicable), endocrinology, infectious disease, mental health, oncology, outpatient dialysis, primary care and rheumatology.*

□ Continuity of care

- Are consumers in active treatment allowed to continue their treatment with the same provider if their provider leaves the network or is reclassified into a higher cost-sharing tier in the middle of a plan year?

Note: State consumer advocates should continue to work with the state departments of insurance, policymakers and stakeholders to strengthen continuity of care provisions. Consumers, especially those who are pregnant, terminally ill or in the midst of an active course of treatment for a serious medical condition including a behavioral health condition, are allowed to see their providers for at least 90 days or until the course of treatment is completed at in-network cost-sharing rates. It is important to note that the 90-day transition period should be the minimum, rather than the maximum, length of time. However, patients with a terminal illness should be allowed to continue with their provider until

45 CFR § 156.230

QHPs in all FFMs are required to ensure continuity of care for enrollees in cases where a provider is terminated without cause, specifically allowing enrollees in active treatment to continue treatment until the treatment is complete, or for 90 days, whichever is shorter.

the end-of-life, even though this may extend beyond 90 days. In addition, consumers in treatment with mental health or substance use disorders providers who are reclassified into a higher cost-sharing tier should continue to pay for services at the lower cost-sharing tier level for at least one year in order to minimize disruption in care. Finally, a consumer who is protected by these continuity of care provisions and is undergoing active treatment from a new provider after their current provider was terminated without cause should be protected from [balance billing](#).

Affordability

Consumer protections from balance billing

- Are consumers able to access out-of-network providers at in-network cost-sharing levels if there is no in-network provider for a covered service?
- Are consumers protected from out-of-network cost sharing in cases when they could not be reasonably expected to know or control whether care was being delivered by out-of-network providers (i.e. out-of-network anesthesiologist at in-network hospital or for emergency care)?
- Are consumers who receive treatment from out-of-network providers due to incorrect or out-of-date information in the provider directory subject to out-of-network cost sharing?

Currently, there are no federal requirements that prohibit balance billing by out-of-network providers or limit the financial liability associated with out-of-network services to consumers.

Note: In the past two years, [one third](#) of privately insured Americans received a surprise medical bill. These surprise medical bills can add up to hundreds or thousands of dollars, driving consumers into exorbitant medical debts. A number of studies found that most surprise medical bills occurred in emergency care settings or when insured individuals are inadvertently treated by out-of-network providers in in-network facilities. Due to the lack of consumer protections in federal law, consumer advocates should continue to advocate for solutions that protect residents from unexpected out-of-network bills at the state level. A [number of states](#) have proposed or adopted the following provisions that protect consumers from surprise medical bills in the following situations: (1) unavailability of in-network providers for a covered essential health benefit (EHB); (2) unexpected utilization of out-of-network care for a covered EHB; (3) emergency care; and (4) out-of-network care as a result of an inaccurate provider directory.

Quality

Inclusion of [Quality Improvement Strategies \(QIS\)](#) into provider selection criteria

- When selecting providers to be included in the plan network, do health plans implement a quality improvement strategy to improve health outcomes and reduce health disparities?
 - Do health plans adopt standardized

ACA §1311(c)(1)(D)(E)(H)(I); 45 CFR §156.1130

- *Health plans are required to implement a QIS, which is a payment structure that provides increased reimbursement or other incentives to improve health outcomes, reduce hospital readmissions, improve patient safety and reduce medical errors, implement wellness and health promotion activities, and reduce health and health care disparities.*
- *Health plans participating in marketplaces for at least two years must report QIS information to the public.*

- quality metrics that include measures on health outcomes to select providers?
- Do health plans implement a payment structure that provides incentives for providers to deliver quality care?
 - Are language access services available including American Sign Language and Braille?
 - Do health plans implement strategies to reduce health disparities (such as collecting data on quality measures stratified by demographics to uncover disparities, implicit bias and diagnostic errors, as well as identify intervention points and strategies)?

Note: At minimum, health plans should adopt standardized quality metrics as one of the key criterion to select providers to be included in the plan networks. These quality metrics include: (1) the [Healthcare Effectiveness Data and Information Set \(HEDIS\)](#), the [Consumer Assessment of Healthcare Providers and Systems \(CAHPS\)](#) survey and [Core 24](#) and any new measures developed via the Pediatric Quality Measures Program (PQMP). In addition, QIS should include common collection and reporting standards that can be easily understood and compared as a mechanism to foster accountability. Public reporting should factor in the multiple end-users who will be engaged in evaluating QIS activities: state oversight and marketplaces, health plans, consumers, employers, providers and provider organizations. It is important to use consumer-tested language to ensure measures are collected and reported in a uniform format that are publicly displayed.

Transparency

Accurate provider directories

- What steps do health plans take to keep their provider directories up to date, accurate and complete?
 - Are consumers able to access provider directories without submitting an account or policy number?
 - Are consumers able to determine which providers are in the network and which are accepting new patients?
 - Are consumers able to easily search the provider directory by tier, product, languages spoken by the provider, disability access, cost-sharing information and specialty and subspecialty providers?
 - Are provider directories updated at least monthly?
 - Does the Department of Insurance (or relevant state agencies) play an active role conducting regular audits or monitoring?
 - Do health plans provide consumers a clear way to report various inaccuracies in provider directories and are reporting options accessible by consumers in a variety of languages, including American Sign Language and Braille?

45 CFR §156.230

- *At a minimum, health plans must update their provider directories once a month and make them available online to both enrollees and consumers shopping for coverage without requirements to log on or enter a password or policy number.*
- *Provider directories must include information on which providers are accepting new patients in a manner that is easily accessible to plan enrollees, prospective enrollees, the state, the marketplace, Health and Human Services (HHS) and the Office of Personnel Management (OPM).*

- Are printed provider directories updated automatically and sent to plan enrollees every six months?

Note: Enrollees should be able to request additional printed copies of a provider directory at any time with the understanding that insurers will update the provider information at least every 30 days.

Timely consumer notification

- Do health plans provide timely notices to consumers when there are changes in provider network?
- Do health plans take sufficient steps to provide consumers with up-to-date, easy-to-understand information in regard to providers being reclassified into higher cost-sharing tiers within the plan network?

45 CFR § 156.230

QHPs must provide written notice to all enrollees who are patients seen on a regular basis by the provider or receive primary care from the provider of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable.

[2017 Letter to Issuers in the Federally-Facilitated Marketplaces](#)

CMS intends to label each QHP network's breadth as compared to other QHP networks on HealthCare.gov. This information will be available to consumers when they are considering which plan to enroll in and would include a designation that indicates the network's relative breadth.

Transparency of network breadth

- What steps do health plans take to provide information on network breadth to consumers so they can make the right choice when selecting plans to enroll?

Transparency of provider performance

- Do health plans report on quality improvement ratings of providers to the public in a way that is meaningful to consumers? Such as:
 - Measures of member experience:
 - How long is the wait time for appointments?
 - How far is the travel to providers?
 - How likely are enrollees to report that they are confident they have the knowledge and resources to manage their health?
 - Measures of primary care system/coordination:
 - How likely is a person to be admitted or readmitted to the hospital for treatment that could be provided in a doctor's office or community setting?
 - If a person receives behavioral health services, do their behavioral health providers communicate regularly with their primary care provider or other medical/surgical specialists?
 - Measures of clinical quality:
 - Of those admitted to a hospital, how likely are they to develop a preventable complication or infection during their stay?
 - Measures of plan efficiency/affordability:
 - Does the plan exceed the required medical loss ratio (MLR)?

Conclusion

As millions of people gain marketplace coverage, it is important that consumers have access to needed care in a timely manner. Advocates should use this network adequacy checklist to work with state regulators and other key stakeholders to strengthen state standards as well as monitor enforcement of current requirements so that consumers have a positive experience shopping for and using their QHP coverage.

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