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. 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[1], we suggest the following five principles—*availability, accessibility, affordability, quality and transparency*—to unite consumer groups in their advocacy for network adequacy standards that ensure affordable access to the highest quality providers.[2]

Availability	
Health plans must be held accountable for providing access to all covered services.	
ACA requirements & HHS guidance	**Consumer priorities**
Ensure sufficient choice of providers[3] □ 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. □ Out-of-network providers cannot be counted for purposes of meeting network adequacy requirements.	**Key questions to consider:** 1. Do health plans measure access based on providers in the lowest cost-sharing tier for every covered service? 2. Do health plans offer networks with a sufficient number of culturally and linguistically competent providers? 3. 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 (with particular attention to pediatric age or older adults)? For example, do they exclude providers who have experience providing care for the LGBT population? 4. 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?

Inclusion of Essential Community Providers (ECPs)[4]	*Primary care providers (PCPs)*
□ 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."	□ Do health plans include a sufficient number of PCPs in-network for each of the following primacy care categories: family physicians and practitioners, general physicians and practitioners, internists and pediatricians?
□ Plans must include 30% of available ECPs in the plans' service area.	*Specialty care providers* □ 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 and dental providers)?
□ Plans must include specific ECP provider types in each ECP category.[5]	□ Do health plans include providers specialized in: • LGBT health care including treatment for gender dysphoria? • Women's health issues? • Both mental health and substance use disorders services? • Chronic diseases (such as cancer treatment, HIV/AIDS, diabetes, etc.)?
Non-discrimination protections[6] □ 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 include a full range of pediatric providers including pediatric subspecialists, pediatric dental providers and providers that provide care to children with special needs?
	□ Do health plans include provider facilities that ensure accessibility for consumers with disabilities by complying with the ADA?
	Ancillary service providers □ Do health plans include providers that provide ancillary services such as diagnostic services, home health services, physical therapy, speech therapy and occupational therapy?
	Essential Community Providers (ECPs) □ Do health plans have a sufficient number of ECPs to provide care for low-income and medically underserved consumers?[7]
	□ 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?

Accessibility	
Health plans must maintain an adequate network that ensures timely access to needed care.	
ACA requirements & HHS guidance	**Consumer priorities**
Ensure timely access to needed care[8] □ Health plans are required to ensure all services will be accessible without unreasonable delay.	**Key questions to consider:** 1. Do health plans include clear quantitative access standards[9] that ensure timely access to care for consumers as required for health plans participating in Medicaid Managed Care[10] and Medicare Advantage[11]? □ 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 and 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?
Affordability	
Network limits should not result in unaffordable health insurance costs.[12]	
ACA requirements & HHS guidance	**Consumer priorities**
There are no federal requirements to protect consumers from "balance billing"[13] from out-of-network providers and for other out-of-network cost sharing or spending for non-essential health benefits.[14]	**Key questions to consider:** 1. Are consumers able to access out-of-network providers for in-network cost-sharing if there is no in-network provider for a covered service?[15] 2. 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? 3. Are consumers able to continue their treatment with the same provider under the same in-network cost-sharing rules if their provider leaves the network or is reclassified into a higher cost-sharing tier in the middle of a plan year?[16] 4. 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?

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Quality
A high-performance network should also deliver quality care.

ACA requirements & HHS guidance	Consumer priorities
Requirements on Quality Improvement Strategy (QIS)[17] □ 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.	**Key questions to consider:** 1. 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 quality metrics that include measures on health outcomes to select providers?[18] □ Do health plans incorporate consumer activation measures?[19] □ 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)? 2. When reporting on quality improvement ratings of providers, do health plans communicate these ratings in a way that is meaningful to consumers?[20] 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)?

Transparency
Provider networks must be exceptionally clear, accurate and accessible to consumers[21]

ACA requirements & HHS guidance	Consumer priorities
Ensure accurate and up-to-date provider directories[22] □ A QHP issuer must publish an up-to-date, accurate, and complete provider directory, including 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). □ 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 a policy number. **Ensure transparency** □ Insurers are required to report to HHS and state Insurance Commissioners on enrollees' cost-sharing and payments with respect to any out-of-network coverage.[23]	**Key questions to consider:** 1. 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 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?[24] □ How often are provider directories updated? □ 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? □ Do health plans take sufficient steps to provide consumers with up-to-date and easy-to-understand information in regards to providers being reclassified into higher cost-sharing tiers within the plan network? □ How often are paper provider directories updated?[25]

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[1] Community Catalyst (January 2014). Network Adequacy: What Advocates Need to Know. http://www.communitycatalyst.org/resources/publications/document/Network-Adequacy_what-advocates-need-to-know_FINAL-01-28-14.pdf

[2] Community Catalyst (January 2014). Finding Common Ground: Network Adequacy Principles. http://www.communitycatalyst.org/resources/publications/document/Principles-for-Network-Adequacy-FINAL-01.28.14.pdf

[3] ACA §1311(c)(1)(A)(B); 45 CFR §156.230.

[4] ACA §1311(c)(1)(C); 45 CFR §156.235.

[5] CMS/CCIIO (February 2015). Final 2016 Letter to Issuers in Federally-facilitated Marketplaces. http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf

[6] ACA §1303, §1312, §1557 and §2706.

[7] **Standards on the inclusion of Essential Community Providers (ECP)** – HHS requires health plans to include 30% of available ECPs in the plans' service area. However, health plans must apply state rules if they are stronger than either the 30% HHS requirement or proposed 50% threshold. In Connecticut, health plans sold in the Marketplace in 2015 were required to include in their networks 90 % of the federally qualified health centers in the state and 75 % of ECPs on the Marketplace's non-FQHC essential community provider list. In Washington, health plans must include at least 75 % of all school-based health centers in the service area in their networks by 2016. For existing state standards on ECP inclusion, please check this resource http://kff.org/other/state-indicator/contract-offering-and-signing-standards-for-essential-community-providers-ecps-in-marketplaces/

[8] ACA §1311(c)(1)(A)(B); 45 CFR §156.230.

[9] In 2014, about half of states had access standards for managed care health plans to ensure reasonable access to in-network providers. These standards most frequently seek to satisfy quantitative measures of sufficiency such as maximum amount of travel time and/or distance, wait time for appointments, minimum ratios of providers to enrollees and extended hours of operation. For more information, see: http://www.commonwealthfund.org/publications/issue-briefs/2015/may/state-regulation-of-marketplace-plan-provider-networks

[10] National Health Law Program (September 2013). Network Adequacy in Medicaid Managed Care: Recommendations for Advocates. http://www.healthlaw.org/issues/medicaid/managed-care/network-adequacy-in-medicaid-managed-care#.VUy7i010x1s

[11] The Center for Medicaid and Medicare Services (2011). CMS Medicare Advantage Network Adequacy Development Overview. http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/downloads/2011_MA_Network_Adequacy_Criteria_Overview.pdf

[12] **Affordability** - Costs are often a major barrier to low and moderate-income families obtaining coverage and accessing care. One of the key priorities of consumer advocates is to try to ensure that coverage and care is affordable – especially to low and moderate-income families. While there is no gold standard for defining precisely what is affordable, one helpful metric is to determine what percentage of income a household can devote to health care while still having sufficient income to address other necessities. Since many health insurance plans on the market today have high cost sharing, any measure of affordability should account for out-of-pocket costs along with premiums.

[13] **Balance billing** - When a patient receives services from a health care provider that does not participate in his or her insurer's network, the health care provider is not obligated to accept the insurer's payment as payment in full and may bill the patient for the unpaid amount. http://www.communitycatalyst.org/resources/tools/glossary

[14] **The maximum out-of-pocket costs** for any Marketplace plan for 2016 are $6,850 for an individual plan and $13,700 for a family plan. This limit does not have to count premiums, balance billing amounts for non-network providers and other out-of-network cost-sharing, or spending for non-essential health benefits. For more information, see: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/2016-PN-Fact-Sheet-final.pdf

[15] **Example of strong requirements to protect consumers from surprise medical bills** - New York recently passed a law to strengthen standards for network adequacy, which requires transparent information about out-of-network providers and reimbursement levels, expands consumers' appeal rights for treatment decisions, and creates an independent arbitration process when the health plan and provider can't agree on cost.

[16] **Ensuring continuity of care** - 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. In addition, consumers in treatment with mental health or substance use disorder 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.

[17] ACA §1311(c)(1)(D)(E)(H)(I); 45 CFR §156.1130.

[18] **Quality metrics**: 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).

[19] **Patient activation measures**: Patient engagement, including patient activation and patient confidence, is an increasingly important strategy for achieving better health outcomes and care experiences. The patient activation tools have the potential to elevate the role of the patient in his/her own care and to equip the patient with the confidence and knowledge necessary to take action to manage and improve his/her own health. http://content.healthaffairs.org/content/32/2/207.abstract

[20] **Quality improvement strategy** (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.

[21] **Examples of strong requirements to ensure accurate provider directories** - California recently introduced a bill requiring health plans to 1) maintain an accuracy rate of at least 97% for their provider directories by updating them weekly; and 2) provide an email address and a telephone number for consumers or shoppers to notify health plans if any information on the provider directory appears to be inaccurate.

[22] 45 CFR §156.230(b)(1)(2).

[23] ACA § 1311(e)(3); PHS Act § 2715A.

[24] Specific attention should be paid to fields that often present challenges for consumers seeking care (e.g., pediatric specialties, substance use disorders, and mental/behavioral health).

[25] **Updating paper provider directories** – Printed provider directories should be updated and automatically sent to plan enrollees every 6 months. Enrollees may 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.