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Re: Oversight of Network Adequacy

We write to provide recommendations concerning network adequacy review for marketplace plans. Thank you in advance for considering these comments as you prepare stronger oversight procedures pursuant to the Columbus case and the *No Surprises Act*. Since the No Surprises Act applies to group as well as individual plans, CMS can use this opportunity to analyze differences between health plan networks serving employment-based plans and individual plans, with an eye to strengthening protections and providing indicators of network breadth across markets.

Inadequate networks have been particularly concerning for mental health and addiction services. The Bipartisan Policy Center's Behavioral Health Integration Task Force recently recommended strengthening network adequacy standards across HHS-regulated plans to address lack of access to needed services.

Provide Consumer Information Regarding Networks

We look forward to implementation of further directory accuracy standards pursuant to the No Surprises Act. While current marketplace regulations require publication of an up-to-date and accurate provider directory, the No Surprises Act builds additional protections by requiring plans to establish a directory verification process and to update provider databases within two days of a change. CCIIO should ensure that plan procedures prevent billing when the consumer relied on an outdated or inaccurate directory. Consumer facing provider databases must be easily searchable, accessible, and include information about facility/provider specialties, their national provider identifier number (NPI), the accessibility of their locations to people with disabilities, whether they are accepting new patients, and about the languages spoken by providers and their staffs. For oversight purposes, CCIIO should require plans to transmit directories to the federal government.

Marketplaces should provide an easy-to-understand indicator of network breadth to help consumers evaluate their enrollment choices. For example, the indicator could show the percentage of hospitals/doctors (or the percentage of Medicare participating providers), broken out by key

facility/provider types or specialties, within the geographical service area that are in-network for the marketplace plan, providing a ranking of network size.

To that end, CCIIO should immediately require QHPs to submit their provider network directories (with detail including the NPI number(s) of each participating provider and facility, the specialty, whether each is taking new patients, language capabilities, and accessibility for patients with disabilities. Submission should be at application for certification, and then monthly, with changes highlighted (who left, entered, etc.) with each submission. CMS should carefully review these directories. Initial review should focus on what information is contained or missing with the goal of developing numeric standards for adequacy.

Strengthen Data Collection Regarding Out-of-Network Claims and Act on Red Flags

CMS requires limited reporting of transparency data under the Affordable Care Act by federal marketplace plans. Currently reported transparency data already provides some information about the number of out-of-network claims denials, though data on out-of-network claims submitted is not reported. Using what is currently available, CMS should now begin to review plans with high numbers of out-of-network denials for their size. CMS should significantly strengthen this dataset by requiring data on the total number of out-of-network claims *submitted*, and computing a denial rate. High rates of denials should prompt review. Further, CMS should collect data on the types of providers and services involved in out-of-network claims as one possible indicator of the types of care for which networks must be strengthened. In addition, reporting on out-of-network claims for emergency services and on out-of-network services provided within in-network hospitals and facilities will support oversight of new surprise medial bill standards.

CMS should audit a sample of state reviews of network adequacy, and audit in response to red flags or consumer complaints. CMS should also review formulary adequacy. Further, states and CMS should conduct some direct tests or provider availability, similar to the HHS Office of Inspector General's 2014 recommendations for direct testing of Medicaid provider networks.

Establish Appointment Wait Standards, in Addition to Time and Distance Standards

Appointment wait time is an important metric and is the best indicator of availability. It is particularly important for substance use disorder (SUD) and for mental health (MH) services (differentiated and measured separately). Wait times should include metrics for crisis/urgent/emergency services and routine visits. All metrics must be compliant with the Mental Health Parity and Addiction Equity Act, as network adequacy, carrier credentialing and provider admission practices are subject to these non-discrimination standards. Standards regarding appointments waits, and travel time and distance should be pass/fail – plans should not be permitted to operate with inadequate networks and those that do not have adequate network providers must ensure that members have access to mandated benefits through a non-participating provider at no greater cost than their network payment.

Maryland's draft regulations may be a helpful model for time, distance, and appointment waits by type of services. The draft includes standards specific to urban, suburban, and rural geographic areas, and includes requirements to contract with essential community providers: Network Adequacy Regulations Information (maryland.gov). The Legal Action Center/Partnership to End Addiction study, Spotlight on

Network Adequacy Standards for Substance Use Disorder and Mental Health Services, provides additional state-by-state information.

Pay Particular Attention to Mental Health and Addiction Parity

The accessibility of mental health (MH) and substance use disorder (SUD) services is crucial to overall health, achieving parity and addressing health disparities in communities of color. Yet there is reason to believe that plan networks are especially likely to fall short when it comes to ensuring access to these services. Therefore, CMS should pay particular attention to these services in measuring network adequacy. CMS should:

1) Set metrics for crisis/urgent/emergency mental health and substance use disorder services as well as for routine and ongoing visits. Differentiate metrics for SUD from those for MH. All metrics must be parity compliant.
2) Regulate and enforce requirements for plan networks to include sufficient numbers of MH and SUD providers (again separated) to cover the mandated benefits under state and federal law and any additional benefit levels that would be required under the Parity Act (even if not mandated by other laws). Thus, networks should provide adequate coverage of providers who deliver intermediate levels of SUD and MH care – such as intensive outpatient, partial hospitalization, and residential treatment – with at least the same sufficiency at these levels as for other medical care.
3) Regulate and enforce requirements for networks to include the full range of MH and SUD providers and settings (based on a Parity Act analysis) and have sufficient numbers of providers with expertise in the full range of MH and SUD conditions, including providers with a range of licensure types as permitted under state law. As with medical conditions that have specialists who treat common as well as rare conditions, networks for MH and SUD must have providers with specific expertise, including expertise in youth and adolescent treatment as well as adult care: one size of MH practitioner does not fit all. In addition, there is often a range of provider types who can deliver MH/SUD services and plans must ensure their enrollees have access to the types of providers who can deliver the MH/SUD services they need.
4) Regulate and enforce requirements that plans allow for service delivery by non-participating providers at no greater cost to members than in-network services if the network does not have adequate in-network providers.
5) Regulators should consider telehealth services for MH and SUD care for satisfaction of network adequacy, but carriers must have adequate providers of in-person services to meet network requirements. In other words, CMS should not permit a carrier to meet network adequacy standards based on a significant reliance on telehealth providers.

Undertake Meaningful Enforcement Actions That Protect Consumers

Consumers must have a right to go out-of-network at no greater cost if a network is not adequate; and health insurers must be required take immediate steps to improve provider networks that are out of compliance. CMS should work with regulators to issue fines, civil monetary penalties and sanctions to enforce these requirements.

CMS's oversight plan regarding network adequacy should not rely on complaints alone. It should require access plans for new networks; require submission of parity compliance reports on network standards (recently required under the Consolidated Appropriations Act of 2021); use consumer surveys as well as

claims and complaint date to flag issues; and incorporate a regular schedule for sampling and auditing plan compliance, including use of mapping tools to identify possible geographic gaps, and the use of secret shopper surveys to identify areas where networks are failing to provide timely access.

Consumers should have channels to complain to their state and to the federal government regarding network adequacy, the right to appeal denials of out-of-network authorizations and claims, and help from federally funded state consumer assistance programs (CAPs) throughout the process.

Thank you for considering this!

Sincerely,

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