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Addressing Network Adequacy for New Mexico Consumers in Private Insurance and Medicaid Managed Care Plans

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Families USA is a national non-profit, non-partisan organization focused on achieving high-quality, affordable health coverage and care for all. As the Private Insurance Program Director, I have spent much of 2014 researching issues of access to health care providers for consumers once they are enrolled in coverage, along with how various states and the federal government are addressing these issues. I am honored to discuss this issue with the Committee today.

Enrolling in insurance, whether private coverage or Medicaid, is often considered the key to accessing health care. And it is a critical step to being able to obtain necessary medical services. But unfortunately, a health insurance card does not always guarantee access to care. As one of my colleagues put it, a health insurance plan is like a cell phone- it is only as good as the network it's on.

Consumers and their advocates have raised concerns with the adequacy of provider networks in both private coverage and Medicaid for decades. These concerns include problems with provider directories, such as situations in which plans' directories may list hundreds of providers as included in their networks, but once consumers start calling those providers' listed numbers, they find the providers are no longer working in the area, or the numbers are dead, or even the providers are dead. And they include problems with the networks themselves, such as enrollees struggling to find in-network primary care providers who are accepting new patients or are located within a reasonable distance from their homes or workplaces, or enrollees struggling to find in-network specialists who meet their medical needs. These types of problems have always existed, but in certain areas people report that they may have worsened recently. Here are some thoughts on why this might be:

Plans want to be price competitive, and as advocates, policymakers, and consumers, we want them to be price competitive. But we want them to use the right tools to be price competitive. In the past, health plans in the private individual market could use some tools that were unfriendly to consumers to hold down their prices. For example, they could avoid paying for care by refusing to sell coverage to people with pre-existing conditions. But the Affordable Care Act now forbids this discriminatory practice. And, it encourages more competitive pricing through the marketplaces, where shoppers can now see how each health plan's prices stack up against all of the other options in the marketplace- a very good thing for consumers. So in this new environment, plans are looking for different ways to be price competitive, and one of the tools they are using is network design. And this is not necessarily bad for consumers. But, if plans use networks to help control their costs, they must do so in a thoughtful manner.

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Plans should design networks to help control costs while still delivering necessary, high-quality care. They should be carefully shaping networks using quality and value metrics to select providers, but first and foremost always making sure that there is a sufficient number, variety, and appropriate geographic distribution of providers in the network. But we are concerned that in certain areas, instead of going through this thoughtful process, some plans may be bluntly excluding the providers and facilities that they deem too expensive from their networks without first ensuring that the network is still adequate in size, geographic distribution, and breadth of specialties to serve the enrollee population.

A network does not necessarily need to include every provider or facility in an area in order for it to be adequate. But it does need to be able to provide consumers the right care, at the right time, without them having to travel unreasonably far. To ensure that plans can achieve this level of network adequacy for enrollees, states, including New Mexico, must ensure that they have sufficient network adequacy laws and regulations, and they must adequately enforce these laws and regulations. The testimony that follows outlines:

- **New Mexico's current network adequacy regulations for private managed health care plans and Medicaid managed care plans**
- **Recommendations for improving monitoring and enforcement of New Mexico's network adequacy regulations**
- **Recommendations for strengthening New Mexico's standards for the inclusion of Essential Community Providers in health plan networks to improve network adequacy**

New Mexico's Network Adequacy Regulations

The state of New Mexico has already taken key initial steps to ensure that networks in both private plans, including marketplace plans, as well as networks in Medicaid managed care Plans are adequate for residents. Unlike some states, New Mexico has regulations outlining baseline consumer protections for network adequacy in both private and Medicaid managed care plans.

Section 13.10.22 of the NM Administrative Code, entitled "Managed Health Care Plan Compliance," requires that in private managed care plans, including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and other plans that require or incentivize enrollees to use providers managed, owned, under contract with or employed by the plan, there should be (among other requirements):

- Two PCPs [primary care providers] available within no more than 20 miles or 20 minutes average driving time for 90 percent of the enrolled population in areas of 50,000 or more residents; in population areas of less than 50,000, there should be two PCPs available within no more than 60 miles or 60 minutes average driving time for 90 percent of enrollees. (For remote rural areas, the Superintendent of Insurance determines on a case-by-case basis whether sufficient PCPs are available.)
- One full-time equivalent PCP available for every 1,500 enrollees.

The rule also requires that plans make available provider directories that indicate which providers are not currently accepting new patients and sets some standards for appointment wait times, access to out-of-network services, language access, and other consumer network needs.

Section 13.10.13 of the NM Administrative Code, entitled "Managed Health Care- Benefits" also sets some network adequacy requirements for private managed care plans. For example, it outlines the consumer right "to adequate access to qualified health professionals for the treatment of covered benefits near where the covered person lives or works within the service area of the MHCP [managed health care plan]."

In many ways, New Mexico has even stronger rules in place for network adequacy in Medicaid managed care plans under NM Administrative Code Section 8.308.2, "Provider Network." In addition to having travel time and distance standards for primary care providers and pharmacies, this rule sets appointment wait time standards such that:

- For routine, asymptomatic, member-initiated, outpatient appointments for non-urgent primary medical and dental care, as well as for non-urgent behavioral health care, the request-to-appointment time shall be no more than 14 calendar days, unless the member requests a later time.

- For specialty outpatient referral and consultation appointments... the request-to-appointment time shall generally be consistent with the clinical urgency, but no more than 21 calendar days, unless the member requests a later time.

Another very important part of the Medicaid managed care Provider Network rule is a provision allowing enrollees to see out-of-network (or "non-contracted") providers if the managed care organization (MCO) is unable to provide an in-network provider that can deliver covered benefits "in an adequate and timely manner." In these instances, "the MCO must ensure that the cost to its members utilizing a non-contracted provider is not greater than it would be if the service was provided within the MCO's network."

Under another rule, New Mexico Administrative Code 8.308.7, entitled "Enrollment and Disenrollment," Medicaid managed care Enrollees may request to switch managed care plans, even mid-year, for causes including "poor quality of care, lack of access to covered benefits, or lack of access to providers experienced in dealing with the member's health care needs."

Together, these rules are an acknowledgement that residents in private and Medicaid managed care Plans deserve access to providers that can deliver all of the services to which their health plan contracts entitle them, in a timely matter, without having to travel unreasonably far.

Monitoring and Enforcement Should be Strengthened

There are certainly ways that New Mexico could strengthen its network adequacy protections, such as by implementing for private managed health care plans through regulation or statute:

- Specific standards for access to specialists,
- Stronger standards to hold insurers accountable for the accuracy of provider directory information,
- Stronger appointment wait-time standards, and
- Rights for consumers to go out-of-network at no extra cost when no in-network providers are available.

However, the fact that New Mexico has regulations in place for private and Medicaid managed care plans means that New Mexico has already taken the first important step to ensuring that provider

networks are adequate for enrollees. Many states have not yet taken this step, so New Mexico should be commended for implementing these important baseline protections.

Despite these regulations, consumer problems with network adequacy in private and Medicaid managed care plans still frequently persist, even in well-populated areas of the state. This indicates that stronger network adequacy monitoring and regulatory enforcement is needed. I would therefore like to provide the following recommendations for improving network adequacy monitoring and enforcement:

- **Assess and enhance regulatory agency capacity:** Generally, one of the main reasons that states struggle with insufficient network adequacy monitoring and enforcement is that their responsible agencies are not sufficiently staffed and resourced. In light of this, the Committee could assess whether the Office of the Superintendent of Insurance (OSI) and the Human Services Department have sufficient staff and financial resources to adequately monitor plans' compliance with the aforementioned network adequacy regulations and to take enforcement actions when plans are found to be out of compliance. For example, the agencies may have the capacity to respond to individual consumer complaints, but do they have the capacity to mount comprehensive investigations of plans' networks if complaints seem to indicate systematic problems? If the agencies are found to have insufficient capacity, the Committee could pursue avenues to bring the agencies to staffing and resource levels as necessary to monitor for and enforce compliance with all applicable regulations, and request regular reports on the state's progress getting the agencies to that point.

- **Strengthen network adequacy monitoring:** Having quantitative network adequacy standards, as New Mexico does in regulation, is critical to ensuring consumer access to providers. But without formal monitoring, it is impossible to know whether plans are actually complying with these standards. Ideally, regulatory agencies conduct formal reviews of compliance with up-to-date network and enrollee data, and the Health and Human Services Committee could consider requiring or recommending that they do so. In lieu of that, non-profit organizations, universities, or other entities could also complete formal assessments if they had access to the proper data. For example, they could map where plans' in-network providers are located relative to where Medicaid MCO and private managed care plan enrollees live and/or work to determine whether plans appear to be in-compliance with network adequacy regulations.

  In addition, some states, such as Arkansas,[i] require plans themselves to submit GeoAccess maps each year demonstrating where their in-network providers are located and the travel time and distance radius around them. The Health and Human Services Committee could consider implementing such a requirement in New Mexico to make it easier for regulators to assess whether Medicaid and private managed care plans are in compliance with quantitative network adequacy standards. Finally, the Managed Health Care Plan Compliance regulation grants OSI authority to "conduct or arrange for periodic satisfaction surveys of covered persons," and the Committee could recommend or require that such a survey be used specifically to assess whether plan enrollees are experiencing network adequacy problems.

- **Monitor with secret shopper studies:** Secret shopper studies are used to assess the accuracy of provider directories, as well as to monitor network adequacy. By sampling providers listed in directories and calling them to assess factors such as whether their contact information is correct, whether they are really in a plan's network, whether they are available to see new patients, and when their next available appointment is, researchers can assess the accessibility of care in a plan's

network. The Health and Human Services Committee could consider requiring or recommending the use of secret shopper studies to assess the accuracy of provider directories and the adequacy of networks in the states' private and Medicaid managed care plans. State regulators or other officials, non-profits, universities, or other entities could conduct these studies.

- **Improve Enforcement:** When plans are found to be out of compliance with network adequacy requirements, regulators should first notify the plan of the issue and provide the plan an opportunity to correct the problem. However, if this remedy does not prove sufficient, the Health and Human Services Committee should ensure that the state pursues more intensive actions to ensure consumers' rights to access to providers are upheld.

  New Mexico's Managed Health Care Plan Compliance rule authorizes the Superintendent of Insurance to impose monetary penalties for violations of network adequacy requirements, and such penalties should be imposed for plans that demonstrate continued failures to correct network deficiencies. In addition, the Committee should consider requiring or recommending that regulators utilize other remedies to correct deficiencies in both private and Medicaid managed care plans, including:

  - Restricting service area: Regulators could restrict the service area in which plans can sell policies or enroll individuals to zip codes in which the plans have a sufficient number and variety of providers located directly or within reasonable proximity until network deficiencies in problem areas are ameliorated.

  - Restricting the sale of new policies/ enrollment of new clients: Regulators could prohibit plans from accepting new enrollees altogether until they are able to correct network deficiencies and provide access to all covered services in a reasonable and timely manner to currently covered individuals.

  In situations where financial penalties and other restrictions still do not lead to corrections of continued and severe network insufficiency, it is appropriate to consider whether a plan's authority to operate as a private managed health care plan or Medicaid managed care plan should be revoked, or at least suspended. The Superintendent of Insurance has the authority to suspend, revoke, or refuse to continue an insurer's certificate of authority or license, and the Health and Human Services Committee should ensure that OSI considers using this authority if any plans in New Mexico consistently demonstrate egregious network adequacy problems. The Committee should also ensure that the Human Services Department has appropriate authority and uses that authority to take similar actions with Medicaid managed care plans should they ever demonstrate egregious network deficiencies over time.

Stronger Essential Community Provider Standards Could Improve Health Plan Networks

To conclude my testimony, I would like to address one more area where New Mexico should consider implementing stronger standards. The Affordable Care Act requires that health plans sold in the marketplaces include in their networks essential community providers (ECPs) that serve predominantly low-income, medically underserved individuals. These include providers such as federally qualified health centers (FQHCs) and "look-alike" health centers, Ryan White HIV/AIDs providers, hospitals such as Disproportionate Share Hospitals (DSH hospitals) and Sole Community Hospitals, Title X family planning clinics, hemophilia treatment centers, and other providers that serve underserved populations,

including, but not limited to, all other providers that are eligible for discounted prescription drugs under the federal 340B Drug Pricing program.

To implement this requirement, New Mexico is using the same standard that the U.S. Department of Health and Human Services (HHS) is using for federally facilitated marketplaces. Under this standard, marketplace plans must contract with at least 30 percent of the ECPs in their service area. (Although plans that cannot meet this standard may still be able to receive certification to sell marketplace coverage if they submit a sufficient justification and explanation of how they will serve low-income and medically underserved consumers.) HHS determines whether a plan meets the 30 percent threshold using its "non-exhaustive database of essential community providers."[ii]

Other states have determined that the HHS standard is insufficient to ensure adequate access to ECPs, and have implemented much stronger standards. To help plans meet network adequacy requirements for all enrollees, the Health and Human Services Committee should consider requiring or recommending that New Mexico replace its current ECP standards with standards similar to those implemented in the following states:

- **Connecticut:** Plans sold in the marketplace must include in their networks 90 percent of the federally qualified health centers (FQHCs) in the state and 75 percent of ECPs on the marketplace's non-FQHC ECP list.[iii] The marketplace uses its own list of ECPs instead of HHS' database because it found that the HHS database does not include a sufficient number or sufficient geographic diversity of essential community providers in Connecticut.[iv]

- **Montana:** In the Advisory Memorandum to issuers seeking to sell or renew coverage in the individual or small group markets for 2015, the Commissioner of Securities and Insurance (CSI) in Montana describes the federal ECP standards as insufficient and outlines more robust standards for Montana. The memorandum reads, "*The list of ECPs published by [HHS] for Montana is incomplete… I have determined that the federal network adequacy standard that requires only 30 percent of all ECPs to be "in network" is not adequate for Montana. QHP issuers should strive to meet a standard that includes at least 80 percent of all ECPs on CSI's published list. If a health plan is unable to meet that standard, CSI will review the adequacy of the ECP network and make a determination on a case- by- case basis.*"[v]

- **Washington:** Among other specific ECP requirements, regulations in Washington require that marketplace qualified health plans, *"include access to one hundred percent of Indian health care providers in a service area… such that qualified enrollees obtain all covered services at no greater cost than if the service was obtained from network providers or facilities."* [vi]

By following the model set by these states and others that have implemented more robust standards for including ECPs in provider networks, New Mexico could both help improve access to care for low-income, medically underserved individuals, and also help expand plan networks for enrollees overall.

Thank you for the opportunity to provide comments to the Health and Human Services Committee regarding how provider networks can be strengthened for New Mexico residents in private managed health care plans and in Medicaid managed care plans. By focusing on this issue, the Committee can make a great contribution to improving health care, and ultimately health outcomes, for the residents of

New Mexico. **Should you have any questions or need any further information, please contact Claire McAndrew at cmcandrew@familiesusa.org or 202-628-3030.**

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[i] http://www.insurance.arkansas.gov/Legal/Bulletins/9-2014.pdf

[ii] Center for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, 2015 Letter to Issuers in the Federally-facilitated Marketplaces, (Washington, D.C.: U.S. Department of Health and Human Services, March 14, 2014), available online at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf/

[iii] Access Health CT, Solicitation to Health Plan Issuers for Participation in the Individual and/or Small Business Health Options Program (SHOP) Marketplace (Hartford: Access Health CT, March 18, 2014), available online at: http://www.ct.gov/hix/lib/hix/QHP_Solicitation_031814_Amended.pdf.

[iv] Connecticut Health Insurance Exchange Board of Directors, Special Meeting Minutes (Hartford: Access Health CT, June 26, 2013), available online at: http://www.ct.gov/hix/lib/hix/FinalMinutes62613.pdf.

[v] http://csi.mt.gov/news/bulletins/57FormsFilingMemorandum.pdf.

[vi] Washington State Office of the Insurance Commissioner, Insurance Commissioner Matter No. R 2013-22, (Olympia: Washington State, April 26, 2014), available online at: http://www.insurance.wa.gov/laws-rules/legislation-rules/recently-adopted-rules/documents/2013-22103P.pdf.