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Washington, D.C. 20024

January 14, 2019

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
CMS-2408-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-2408-P

Dear Administrator Verma,

I am writing on behalf of the American Psychiatric Association (APA), the medical specialty association representing approximately 37,800 psychiatric physicians and their patients and families regarding the CMS proposed regulations (CMS-2408-P) to revise the Medicaid and CHIP managed care regulations. Our comments concern: 1) the proposal to modify the Network Adequacy Standards for these programs codified at 42 CFR 438.68; and 2) the relationship of these network adequacy standard requirements to the Medicaid regulations codified at 42 CFR 438.910 which regulate the application of the Mental Health and Addiction Equity Act of 2008 (MHPAEA) requirements to Medicaid and CHIP managed care programs.

The principal policy feature of the proposed change to the current network adequacy requirement stipulated at 42 CFR 438.68 (438.68) - the time and distance standard - is to establish a more flexible and meaningful requirement for states. In lieu of the current standard requirement - time and distance - states would be required to establish a quantitative minimum access standard for the providers listed at 438.68 b (1) and (2), which includes mental health and substance use disorder providers. States may elect what standard(s) they will use. The preamble includes a nonexclusive list of the types of standards states may want to consider including minimum provider-to-enrollee ratios; a minimum percentage of contracted providers that are

accepting new patients and maximum wait times for an appointment. States may use different standards in combination and are encouraged, but not required, to do so.

APA agrees with this change if it includes some important qualifications that will move the network adequacy standard requirements in a direction that should enable more meaningful oversight and evaluation by states and CMS of actual patient access to managed care plan networks. Our qualifications respecting the proposed change is three-fold: 1) not all quantitative standards are equivalent regarding what they measure or potentially indicate; 2) the discretion afforded states to choose which standard(s) they will use and whether to use in combination may not be optimal; and 3) the lack of notification as to the relationship of these standards to the requirements of MHPAEA.

There are at a minimum two types of network adequacy quantitative standards and the difference between them is material. The first category of quantitative standards used to assess network adequacy are requirements that certain metrics be fulfilled but are static in terms of the information they convey respecting patient access. These include standards such as time and distance, provider to enrollee ratios and similar benchmarks. The second category of quantitative standards more directly measure a network's actual performance. These include standards such as wait time to appointment, percentage of providers accepting new patients, contracted providers filing claims, exception requests for out of network service among others. To aggregate them into one category has the potential to undermine appropriate assessment of managed care plan networks.

We therefore recommend that CMS: 1) provide additional guidance on potential quantitative standards to the states and create two categories which distinguish between those that may be important but are static as to network performance in real time and those which permit assessment of actual performance; and 2) that states be required, rather than encouraged, to utilize a combination of standards and that the combination include a standard(s) which measures actual network performance.

This is essential for several reasons. 42 CFR 438.206 which governs the Availability of Services requirement stipulates that states ensure all services covered under the state plan are available to enrollees and 438.206(c)(1) requires timely access to covered services. Quantitative measures, which are static, such as provider to enrollee ratios measure only whether providers are theoretically available and may in fact represent a network that also serves several non-Medicaid products. They do not allow for states to fully evaluate whether the access requirements of 438.206 are satisfied or for CMS to provide informed oversight.

Quantitative standards or measures such as wait times provide the potential to assess actual network capacity. Moreover, they afford the ability to assess differences in access performance

to different classes of providers, which is important in the context of MHPAEA compliance as discussed below. It is also important to point out, given that most all the managed care plans are accredited by national bodies, that independently of these regulatory requirements NCQA and URAC have moved to expand their standard requirements regarding plan oversight of their networks' performance. The standards and guidance provided by these bodies has clearly moved in the direction of requiring plans to utilize quantitative metrics that directly relate to network performance. Hence, the burden of moving more aggressively in this direction is not significant and would be in line with where the 'market' is moving.

An additional and significant reason to require states to use some network adequacy standard(s), which enables performance assessment, concerns compliance with the requirements of MHPAEA and specifically the regulatory test governing nonquantitative treatment limitations (NQTs) which these managed care plans and/or states are subject to. Medicaid managed care plans, or states, where multiple delivery systems are utilized, compliance with federal/state statutory or regulatory requirements at 438.68 - the network adequacy standards – are required for approval to operate and is not dispositive of MHPAEA compliance. MHPAEA compliance determination is a separate analytical task.

It is essential to recognize that network adequacy, or inadequacy, is a NQTL under the MHPAEA and therefore subject to parity analysis to determine health plan compliance per the established regulatory tests at 42 C.F.R. 438.910 (d). An NQTL is defined as a plan limitation that is not numerical in nature but otherwise limits the scope or duration of a health plan's benefits. A plan participant's inability to appropriately access in-network treatment is, de facto, a limitation on the scope of the plan's benefits.

Given that health plan network adequacy is an NQTL as defined by MHPAEA regulations, it must be reviewed and evaluated by the regulatory tests for NQTs established under MHPAEA, independent of any federal or state and/or health plan standards requirements. The essence of the NQTL regulatory tests is that it demands a comparative analysis, both as written and in operation, between the mental health and substance use disorder (MH/SUD) benefits and the medical-surgical benefits. **That is, any nonquantitative treatment limitation for MH/SUD must be: 1) developed; and 2) applied in a comparable manner when compared to the plan's medical benefits.**

It is possible that a managed care plan's compliance with state/federal regulatory network adequacy standards can establish comparability as between MH/SUD and medical-surgical network adequacy respecting the "as written" or structural component of the NQTL test. That is, the networks are comparable on their face because they were developed and established by the same required standards and hence no more stringently applied to MH/SUD benefits. Of course, if this were not the case, the MHPAEA "as written" standard would not be met and hence noncompliant.

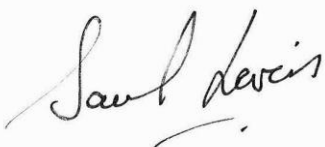
Most often however our experience indicates that the critical parity compliance questions arise in the context of how the respective MH/SUD and medical-surgical networks perform or the “in operation” or “applied” component of the NQTL test. Hence the need for quantitative standards that provide insight as to performance. **Patient access should be comparable as between mental health and substance use disorder providers and medical surgical providers.** 438.68(b)(1) provides a template for provider comparisons in this regard. So for example, material disparities in wait times between beneficiary access to care for behavioral health services (stratified by level of care, program type, facility type) and access to similar medical services may be an indication that parity compliance needs further evaluation. High levels of discrepancy in performance between mental health and substance use disorder and medical network performance should be red flags that suggest more in-depth regulatory review is necessary and may be the basis to examine related factors (e.g. provider reimbursement) which may drive actual provider participation or nonparticipation in a plan’s network and the plan’s network performance respecting behavioral health. Plan criteria governing access to out of network benefits also require examination where applicable.

There are numerous measures a plan or state regulator may utilize to gauge the adequacy of a provider network. As is the case with all NQTLs, evaluation for network adequacy compliance requires looking beyond a plan’s assertion of comparability and theoretical results. That is, a plan may be able to demonstrate network adequacy for MH/SUD with medical-surgical since the same required standards (e.g., geographical access) to establish adequacy are utilized. But the essential question remains as to whether the network is in fact functioning properly—if so, it will satisfy the “in operation” dimension of the parity test?

Given the essential interrelatedness of the network adequacy standards codified at 438.68 and the requirements of MHPAEA at a minimum these regulations should cross reference the requirement that both regulations be satisfied and the basis for this be documented. In our view it would also be useful for CMS to issue additional guidance to the states on utilizing combinations of standards that measure network performance and their utility in fulfilling the required testing for parity compliance.

APA would be happy to meet with you further to discuss out experiences with plan network adequacy and behavioral health and substance use providers and the types of quantitative measures that may be useful to communicate to states. Please contact Sam Muszynski at imuszynski@psych.org with any questions.

Sincerely,

A handwritten signature in cursive script that reads "Saul Davis". The signature is written in black ink on a white background.

Saul Levin, M.D., M.P.A.

CEO and Medical Director