December 19, 2014

Mr. J.P. Wieske and Ms. Matthews
Network Adequacy Model Review (B) Working Group
National Association of Insurance Commissioners
444 North Capitol Street, NW, Suite 701
Washington, D.C. 20001

Dear Mr. Wieske and Ms. Matthews:

Mental Health America supports the National Association of Insurance Commissioners as it works to ensure network adequacy. Based on research in mental health treatment and reports we received from individuals on the ground, Mental Health America would like to propose a few additions to the model that address the particular issues facing individuals with mental health needs. We will first make a general point, then outline the themes that guide our comments, and finally provide section-by-section comments.

First, the overall regulatory regime should incentivize health carriers to have robust networks. Network adequacy regulations are essential but, by themselves, place a tremendous onus on regulators to ensure that networks stay adequate and detect non-compliance; and it is unlikely that health carriers will, on their own, make networks more robust than regulatory compliance requires. Thus, network adequacy regulations should be supplementing an overall regulatory framework that actively promotes network robustness in health carriers. This could include, for example, tying payment to consumer health/recovery outcomes in a way that is responsive to the developing literature on the behavioral economics of pay for performance.¹

Second, network adequacy for individuals with mental health needs requires a focus on three major themes:

- **Continuum of Care**
- **Creativity in Network Design**
- **Quality Assurance**

**Continuum of Care.** Mental health needs are not most effectively treated by regular, short therapy sessions and occasional medication management. Mental health needs are most effectively treated by care teams that work together to promote an individual’s plan for recovery, including primary care physicians who assess mental health needs, peer specialists who accept warm hand-offs in different settings and support the individual in planning and pursuing their recovery, and therapists and psychiatrists who also see the individual’s plan for recovery as the goal and support

them as members of the team.\(^2\) Note that peer specialists are a key part of improving accessibility, as they can communicate in-person, by phone, and even by text message to support consumers. Peer specialists can also join consumers out in the community to most effectively support their recovery.

**Creativity in Network Design.** Health carriers have only recently been asked to comply with the Mental Health Parity and Addiction Equity Act and the Essential Health Benefits provisions of the Affordable Care Act – previously, health carriers may have only covered limited mental health services, if any. Now, health carriers face workforce shortage issues as they try to provide services that they may have limited experience in providing. The Network Adequacy Model Act should support the health carriers in being innovative in creating adequate networks. Unlike other health needs, it is not enough in mental health for the health carriers to simply cover all available mental health clinical providers (i.e. psychologists, psychiatrists, social workers, counselors).

By coordinating needs with appropriate services and having care teams working at the top of their licensure or certification, health carriers can create adequate networks where there is otherwise a workforce shortage. Ideally, networks would integrate peer specialists into different settings, such as primary care, emergency departments, and within communities. Peer specialists are individuals in recovery from mental health needs who have undergone rigorous training to be a member of the care team and support the consumer. Peer specialists help ensure that the consumer accesses the rest of the care team, which may involve assistance with telehealth when therapists and psychiatrists are not accessible, and support the consumer in their recovery. Health carriers should also ensure that acuity of need is matched with the appropriate level of care to maximize accessibility and make the best use of available resources. For some mental health needs, primary care intervention or referral to community-based services and support groups might be most appropriate, while, for other needs, an entire care team, including a psychiatrist, might be most appropriate.

**Quality Assurance.** An adequate network is not only having access to providers, it is having access to actual care. Health carriers must ensure that the services they provide most effectively support consumers to advance in their recovery. Health carriers can ensure a quality network by collecting recovery\(^3\) and/or community inclusion-oriented\(^4\) outcome measures that are based on the consumer’s goals, ensuring providers focus on these outcomes, and providing training and technical assistance to ensure providers are able to promote these outcomes most effectively. Outcome-oriented measurements are preferable to process-oriented measurements because outcomes ensure that consumers are getting better, not just that processes are being followed. Evidence-based training and technical-assistance systems are essential to ensure that health carrier administrators and

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care team members are all working together and are up-to-date on evolving best practices in mental health treatment.5

Mental health quality assurance faces two additional issues as well. First, historic silos in care have limited integration of primary and mental health services and, in some instances, limited primary care provider’s knowledge of mental health services. Quality assurance should address issues in integration. Second, evidence increasingly supports the effectiveness of prevention and early intervention services in mental health care, but penetration of these services in service delivery environments is low.6 When assessing network adequacy and provider quality, health carriers should train providers in prevention and early intervention services and evaluate their delivery throughout the network, as well as measure the effects of these services on consumer developmental7 or recovery outcomes.

Third, with these three basic themes outlined, we would like to share some section-by-section comments of the draft that support these themes.

**Section 3. E. defining “emergency medical condition.”**

“Emergency medical conditions” should include language that explicitly includes psychiatric emergencies.

**Section 3. F. defining “emergency services.”**

Emergency services should be expanded to be inclusive of best practices in mental health, such as mobile crisis teams and peer-run crisis respite, which may not take place in hospital emergency departments. Both mobile crisis teams and peer-run crisis respite make use of highly trained peer and clinician care teams to stabilize psychiatric crises and help the individual get back on track with their recovery. Mobile crisis teams go to where the individual is to provide help. Peer-run crisis respite provides an alternative to emergency departments where staff is trained to best meet the needs of individuals in psychiatric crisis. Note that psychiatric emergency departments are another practice, but may fit within the current definition of emergency services.

**Section 5. B. providing methods for determining network sufficiency.**

In a discussion of network sufficiency, compliance with parity should be mentioned. It is not for mental health services to be covered on parity with general health – we can call parity in service coverage “formal parity.” There must be providers available who provide effective mental health

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5 See, e.g., Brad Karlin and Gerald Kross, *From the Laboratory to the Therapy Room: National Dissemination and Implementation of Evidence-Based Psychotherapies in the U.S. Department of Veterans Affairs Health Care System*, 69 American Psychologist 19 (2014) (evaluating a system for delivering evidence-based treatments in the VA).


treatments and meaningfully address mental health needs to the same extent that general health needs are being addressed in the network – we can call parity in meeting needs “substantive parity.” Substantive parity is more in line with the intent of the Mental Health Parity and Addiction Equity Act and better serves consumers. Section 5B should require substantive parity between general health and mental health as part of network sufficiency.

A discussion of substantive parity in network sufficiency should include a note that this may not be a matter of covering every provider available – substantive parity may require creativity by the health carrier to create a sufficient network where one would not otherwise be available. Telehealth should be used in combination with peer specialists to bolster networks and create an effective continuum of care.

**Section 5. F. enumerating what must be contained in a health carrier’s access plan to ensure network adequacy.**

Health carrier access plans should focus on the creation of care teams that integrate peer specialists into the continuum of care, ensure that providers are working at the top of their licensure, and match need acuity to an appropriate level of care.

**Section 5. F.(7). requiring health carriers to provide certain information about the network to customers.**

Health carriers should not only have to inform those that have enrolled in coverage of the plan’s services and features, but they should have to inform persons considering coverage as well. Without adequate knowledge of the details of each plan, consumers will not be able to make informed choices when selecting coverage.

**Section 5. F.(10). requiring continuity of care when a provider’s contract is terminated.**

When peer specialists are integrated into care teams, they can ensure that consumers are connected to a new provider that meets their needs after a previous provider’s contract is terminated. When a provider was not integrated into a care team, a peer specialist can be deployed to facilitate a linkage to a new provider.

**Section 5. F. Drafting note. suggesting quality assurance standards as part of network adequacy requirements.**

Quality assurance is crucial in mental health. Even among the minority of individuals with mental health needs that receive services, few of these individuals receive minimally adequate

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services. Often among those receiving even minimally adequate services, few of these services are evidence-based and may not meaningfully contribute to recovery.

Quality should be determined by a use of a reliable and validated measure of consumer progress toward recovery and community inclusion goals and supported through training and technical assistance, as outlined in the “Quality Assurance” section above.

Section 6. A. requiring providers to be notified of the services they are expected to provide.

When notifying participating providers of the services they are expected to provide, notifications should provide examples of expected services. For example, in mental health, it would not be ideal to say only “therapy” or even “psychosocial therapy sessions.” Instead, the notification should give examples of specific evidence-based practices that treat specific needs. Note that the list of evidence-based practices should be illustrative and designed to set expectations for rigorous and effective treatment, not be comprehensive – providers must be afforded flexibility in service provision to most effectively meet the needs of each individual. Notifications should also explain that providers are expected to promote recovery and community inclusion for the individuals they treat, and that providers are expected to work within care teams with peer specialists and other key stakeholders to best support consumers.

Section 6. F. (3). provides guides for provider network selection and tiering criteria.

A health carrier’s provider selection criteria should promote substantive parity between mental and general health service provision, as explained in our comment on Section 5B. Peer specialists should also be taken into account in designing networks.

Provider selection is another area in which quality assurance comes into play. Because providers may not have previously been measuring recovery and community inclusion outcomes, health carriers should focus on training and coordinating their networks. When health carriers emphasize recovery and community inclusion outcome measurement in conjunction with training and technical assistance for care coordination and evidence-based treatment (including prevention and early intervention), health carriers can create quality networks.

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10 William Torrey, Evidence-Based Practice Implementation in Community Mental Health Settings: The Relative Importance of Key Domains of Implementation Activity, 39 ADMINISTRATION AND POLICY IN MENTAL HEALTH AND MENTAL HEALTH SERVICES RESEARCH 353 (2011).

Section 6. H. requiring health carriers to notify providers of responsibilities with respect to the health carrier’s administrative policies and program.

Providers should be notified of the health carrier’s goals with respect to mental health treatment. This includes a focus on recovery and community inclusion, the use of care teams, and early intervention and prevention. It should be noted that these goals go past what may have been previous clinical goals, such as avoiding hospitalization and medication adherence.

Section 6. L. (3)(a)(ii). providing for specifics in continuity of care when a provider’s contract is terminated.

A “special circumstance” that requires continuity of care should include an example of mental health treatment for which a sudden change in providers would be deleterious. Generally, throughout this section, the use of peer specialists should be encouraged to coordinate between providers to ensure continuous care.

Thank you so much for your time. We look forward to the great reforms that this model act will bring.

Sincerely,

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