January 9, 2015

Mr. J. P. Wieske, Chair of the Network Adequacy Model Review Subgroup  
National Association of Insurance Commissioners  
701 Hall of the States  
444 North Capitol Street, N.W.  
Washington, D.C. 20001-1509

Dear Mr. Wieske:

The National Committee for Quality Assurance (NCQA) appreciates the opportunity to comment on the updated draft of the Network Adequacy Model Act. The Subgroup’s proposed changes are a step towards improving the effectiveness of the Act in overseeing health plan networks, protecting vulnerable consumers and ensuring networks promote quality and value. We applaud the work of the Subgroup, along with the work of the NAIC staff. While many of our comments are in support of the updates, we also have clarifying recommendations and potential additions that could drive both more efficient oversight and better population health. Our full comments are below, including the specific languages recommendations. We look forward to engaging with the Subgroup over the next few months as it works to finalize the Model Act.

**Quality:** NCQA believes that tailored health plan networks must be grounded in strong relationships with high-quality providers. Thus, we strongly support new language that would require health carriers to consider provider performance on quality metrics and patient outcomes when establishing a network plan.¹ Provider networks focused around high quality, efficient providers will help promote the triple aim – better care, better health and lower costs. Importantly, we recommend adding language on “patient experience,” another important aspect of quality that plans could use to develop high-performance networks.

In addition, as a measure developer, NCQA is keenly aware that the lack of performance measures in many areas may sometimes limit plans’ ability to meaningfully assess provider quality. Because of these gaps, we recommend adding “where appropriate and feasible” to the end of the clause in Section 6 Subsection F (3)(c). We would also be happy to discuss further how health plan provider evaluation programs – which are used to create tiers and make network choices – can be designed in a statistically valid, fair, consistent and meaningful way.²

**Role of Accreditation:** We appreciate and support the discussion around the role of accreditation in assisting state reviews of network adequacy. We agree that accreditation is an important tool that insurance regulators may deploy in conjunction with their own oversight. We strongly oppose removing the option for states to deem accreditation.

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¹ Updated Model Act: Section 6, Subsection F(3)(c)  
² Our Physician and Hospital Quality certification program may provide a useful policy framework by which to approach this issue
We also recommend the drafting note specify that health carriers have the ability to submit their accreditation status documentation demonstrating that they have been accredited with the state. In our experience, this is a much more efficient process since regulators are already receiving documentation (e.g., the “Access Plan”) from the health carrier.

**Provider & Hospital Directories:** We support the new language that would require health carriers to have online and in-print provider and hospital directories. These requirements align closely with our Health Plan Accreditation Standards. We also support the new Section 8 Drafting Note that would provide regulators with potential policy tools to improve the accuracy of directories; we are contemplating similar concepts for future updates to our Health Plan Accreditation program.

We have two recommendations that could improve the accuracy and usefulness of the directories. First, we suggest the Subgroup hold further discussion on the proposed requirement for in-print directories to identify if providers are taking new patients. We question whether this policy should apply to online directories only. Due to provider practice patterns, business decisions, changes in contracts and other issues, paper directories that are published annually may be quickly outdated. In those circumstances, consumers picking a plan may be better served by calling the providers' office to inquire about this information. However, we have also heard that health carriers may print out (and mail) versions of their online directory on an on-demand basis, reducing the potential for discrepancies. That approach meets requirements in NCQA's Health Plan Accreditation program and requirements for Marketplace Qualified Health Plans. We look forward to further discussion about this issue with the Subgroup.

Second, we recommend that health carriers be required to identify the source and limitations of each piece of information on the directory. For example, health carriers could identify that they obtained information on a provider’s board certification from their credentialing process, which happens every three years. Our Health Plan Accreditation Standards include a very similar requirement and we would be happy to provide the Subgroup with more detail.

**Out of Network Benefits:** We support new language that would require health carriers to specify a process a covered person may use to obtain a covered benefit from an out-of-network provider. We believe this is important clarifying language that will protect consumers who may need specialty or sub-specialty care that is not available in their network – or even available in their region.

**Updates to the Access Plan:** The Subgroup has proposed several important updates to the Access Plan that health carriers must file. We support these updates, including the new language on telemedicine, which will help regulators understand if and how those technologies are supporting improved access. We also support language that would require health carriers to make public – via their directories – the criteria they used to build their provider network. This language aligns closely with new NCQA Health Plan Accreditation (HPA) standards for Marketplace plans that will take effect in 2015. In addition, we

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3 Updated Model Act: Section 8, Subsections A, B & C
4 Members Rights and Responsibilities: Standard 4 Elements A - J
5 Members Rights and Responsibilities: Standard 4 Element J / 45 CFR 156.230 (b)
6 Members Rights and Responsibilities Standard 4 Elements C & G
7 Updated Model Act: Section 5, Subsection C (2)
8 Updated Model Act: Section 5, Subsection F
9 Updated Model Act: Section 5, Subsection F (1)
10 Updated Model Act: Section 5, Subsection F (4)
recommend the Subgroup consider requiring carriers to make available the criteria they used to pick the hospitals in their network, a parallel policy that is also included in our standards.

**Access for Vulnerable Members:** We support new language that will allow vulnerable members to continue to see a discontinued provider for up to 90 days. For pregnant members in their second or third trimester, they would be able to continue to see their provider through the postpartum period. These policies are industry best practice, mirror our expectations in Health Plan Accreditation, and will codify important protections for consumers. This 90-day window is critical for patients to continue or complete their course of active treatment and work with their health plan to identify a new provider that meets their needs.

Thank you, again, for the opportunity to comment on the updated draft of the Network Adequacy Model Act. Our specific recommendations on changes to the language are below. If you have any questions, please contact our Director of State Affairs, Kristine Thurston Toppe, at topp@ncqa.org or (202) 955-1744.

Sincerely,

Margaret E. O’Kane
President

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11 Updated Model Act: Section 6 Subsection L (2) (b) & (c)
Specific Language Recommendations

- **[Accreditation] Drafting Note:** States may consider accreditation by a nationally recognized private accrediting entity with established and maintained standards that, at a minimum, are substantially similar to or exceed the standards required under this Act, as evidence of meeting some or all of this Act’s requirements. However, accreditation should not be used as a substitute for state regulatory oversight nor should accreditation be considered a delegation of state regulatory authority in determining network adequacy. States should consider accreditation as an additional regulatory tool in determining compliance with the standards required under this Act. Under such an approach, the accrediting entity should make available to the state its current standards to demonstrate that the entity’s standards meet or exceed the state’s requirements. The private accrediting entity or health carrier shall file or provide the state with documentation that the health carrier and its networks have been accredited by the entity. A state may deem a health carrier accredited by the private accrediting entity with standards that meet or exceed the state’s requirements as meeting the requirements of the relevant sections of this Act where comparable standards exist, except that accreditation should never exempt a health carrier from submitting for prior approval or filing, as appropriate, an access plan as required by Section 5 of this Act. States should periodically review a health carrier’s private certification and eligibility for deemed compliance.

- Section 5 Subsection F (4): “The health carrier’s process for making available in consumer-friendly language the criteria it has used to build its provider and hospital networks, which must be made available through the health carrier’s on-line and in-print provider directories;”

- Section 6, Subsection F (3)(c): “Selection criteria shall not be established in a manner: That fails to take into account provider performance on quality, patient experience and patient outcomes metrics, where appropriate and feasible.”

- Section 8. Provider Directories

  B. The health carrier shall make available in print the following provider directory information for each network plan:

  (1) For health care professionals:

  (a) Name;
  (b) Gender;
  (c) Contact information;
  (d) Specialty; and
  (e) Whether accepting new patients.

  (2) For hospitals:

  (a) Hospital name;
  (b) Hospital location and telephone number; and
  (c) Hospital accreditation status; and
(3) Except hospitals, other facilities by type:

(a) Facility name;
(b) Facility type;
(c) Procedures performed; and
(d) Facility location and telephone number.

C. For the online provider directories, for each network plan, a health carrier shall include:

(1) The health care professional information in Subsection B(1) that includes search functions and instructions for accessing additional information on the health care professional, such as:

(a) Hospital affiliations;
(b) Medical group affiliations;
(c) Board certification(s);
(d) Languages spoken by the health care professional or clinical staff; and
(e) Office location(s); and
(f) Whether accepting new patients.

(2) For hospitals, the following information with search functions for specific data types and instructions for searching for the following information:

(a) Hospital name; and
(b) Hospital location; and

(3) Except hospitals, for other facilities, the following information with search functions for specific data types and instructions for searching for the following information:

(a) Facility name;
(b) Facility type;
(c) Procedures performed; and
(d) Facility location.

(4) For the pieces of information about the health care professionals and hospitals referenced in paragraphs 1-3, carriers shall make available through their directories the source of that information and any limitations, if applicable.