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July 30, 2018

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**Office of Regulation Policy and Management  
Department of Veterans Affairs  
810 Vermont Ave., NW  
Room 1063B  
Washington, DC 20420**

**Re: Notice of Request for Information Regarding Health Care Access Standards.**

Anita S. Everett, M.D.  
Maria A. Oquendo, M.D., Ph.D.  
Renée L. Binder, M.D.  
*Past Presidents*

The American Psychiatric Association (APA), the national medical specialty society representing over 37,800 psychiatric physicians and their patients, offers the following comments in response to the Department of Veterans' Affairs "Notice of Request for Information Regarding Health Care Access Standards," published in the Federal Register on June 29, 2018.

Eric M. Plakun, M.D.  
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The mental health needs of veterans and their families are substantial. As a result, it is essential that the VA ensure broad access to quality mental health and substance-use related services and support programs and/or research to better inform policymaking to ensure that medical and mental health support services (now and in the future) are responsive to the specialized needs of our nation's veterans and their families. Our comments focus on the provision of mental health and/or substance use-related services as they relate to the questions outlined in the RFI.

**Assembly  
2018-2019**

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*Speaker*  
Paul J. O'Leary, M.D.  
*Speaker-Elect*  
Seeth Vivek, M.D.  
*Recorder*

The Centers for Medicare and Medicaid Services (CMS) set the standards for most public sector managed care plans. Given that these standards include access to care issues, such as wait times and terms related to exemptions, provider selection, utilization management requirements, and grievances, the APA encourages the VA to review these standards and consider their applicability for meeting the requirements put forth in the MISSION Act. In addition, the VA should ensure that its current and/or future health plans align with the Mental Health Parity Addiction Equity Act (MHPAEA) of 2008. MHPAEA requires that mental health benefits be treated on the same level with medical and surgical benefits under health plans that offer mental and substance use care.

**Administration**

Saul Levin, M.D., M.P.A.  
*CEO and Medical Director*

Network adequacy is a critically component of MHPAEA and all health plans should ensure an appropriate network of all professional levels of providers are included on their panels. Historically, some health plans have manipulated provider networks to risk select, a practice which is detrimental to care for all patient populations. Federal and state laws require health insurance plans to provide beneficiaries with timely access to a sufficient number of in network providers, including primary care and specialty physicians. Network adequacy, however, is not a reality for far too many patients seeking psychiatric care. It is well documented that most health plan directories of psychiatrists purportedly

available to treat plan members are woefully inaccurate and create “phantom networks”. In a November 2017 report by Milliman, they analyzed private insurance claims between 2013-2015, covering 42 million lives and looked at disparities in out of network use for mental health services versus physical health services. The study demonstrated that people are finding care, however not in networks. For example:

- 31.6% of outpatient facility behavioral health care was accessed out-of-network, while only 5.5% of outpatient facility medical/surgical care was accessed out-of-network.
- 18.7% of behavioral health office visits were accessed out-of-network, while only 3.7% of primary medical/surgical office visits were accessed out-of-network.
- 16.7% of inpatient facility behavioral health care was accessed out-of-network, while only 4.0% of inpatient facility medical/surgical care was accessed out-of-network.

Because there is little consistency in how network adequacy is defined, how health plans attest that they possess an adequate network are audited, or how provider directories are monitored through real time provider or consumer data, consumers are often confused when making purchasing decisions and once making those decisions find that the plan they have purchased does not meet their needs.

When plans are permitted to attest that their network is adequate without having to meet specific standards of adequacy, they can hide their efforts to use their network as a tool for selecting the healthiest and least expensive patients to treat, thereby minimizing their risks and costs. For example, plans can narrow the networks that provide mental health care, long term and costly treatment, and in effect discourage patients with mental health care needs from selecting their plans. In past comment letters, the APA has urged adopting a time and distance standard, instead of a provider to covered person ratio to define network adequacy. Although time and distance standards can have limitations when applied to rural areas, they are better measures of adequacy than a physician to beneficiary ratio. Physicians frequently practice part-time in multiple locations, thereby distorting the physician to-covered-persons ratio. Either standard must account for a physicians’ FTE status, as well as whether a physician practices in in-patient settings, therefore not being accessible for outpatient care. Examples of established and well tested geographic access standards include California’s, which currently apply to all state-licensed plans.

In addition, mandating plans to meet time and distance standards does not necessarily go far enough to ensure that patients have timely access to medical care. Patients, particularly those suffering from MH/SUD, need prompt and timely medical care. If plans must only ensure that providers are within a certain distance and travel time, yet patients wait extended periods of time before they can get care, they lack adequate access to care. Providers may not necessarily provide all covered services that fall within their scope of practice, and just because a plan shows that it contracts with a specific provider does not mean that such provider is accepting new patients. As such, we urge adoption of appointment wait time standards, such as those provided in California, as an additional measure of network adequacy.

The APA recommends up-to-date, accurate, and complete provider directories, including information on which providers are accepting new patients, the provider’s location, contact information, specialty, medical group and institutional information easily accessible to prospective and plan enrollees. To ensure accuracy of such directories and rectify discriminatory “phantom networks,” we urged the following requirements:

- **Plans should be required to publish quarterly reports, by provider listed in the directory by specialty, which include the number of claims submitted by that provider in the past quarter.** Providers who have not submitted a reasonable number of claims in the past quarter should be removed from the provider directory. This will ensure transparency in the marketplace as to what providers are involved as part of the network, and as further check that plans do, in fact, have adequate networks for patients MH/SUDs.
- **Plans should also be required to publish on a quarterly basis the number of out-of-network claims and in network claims paid by the plan for each physician specialty.** These reports will help address network adequacy, because:
  - If the out-of-network claims are disproportionate to the in-network claims paid, it would indicate that the network itself is not sufficient; and
  - If the number of out-of-network claims for mental health are disproportionate to the nonmental health claims filed, it would require investigation into why mental health treatment is provided on a less favorable basis under the plan. It will also give the health plan beneficiary who must pay for these services accurate information about the likelihood that a particular carrier will be able to meet their health care needs.
- **Many of the health insurers that contract with physicians use evergreen contracts to engage physicians in their networks and/or contracts that permit the insurer to “re-market” their network participants to other payor entities. These contracts contribute to inaccuracies in the network directories in two ways:**
  - When a physician terminates the agreement pursuant to the contract terms, the health carrier often does not remove the physician’s name from the network; and
  - Because of the age of some of these contracts, physicians do not even have access to them anymore. Therefore, they give notice of termination from the network (perhaps not in accordance with contract time periods without knowing that) and believe they are no longer part of the network, whereas the plan keeps them as part of the network because they did not follow contract termination procedures. Additionally, contracts that allow remarketing of providers result in practitioners having no knowledge that their network participation with one payer has been rented to another with the same fee schedule. Contract with remarketing provisions rarely, if at all, require notice that this has been done. Consequently, patients call the physician and are told that he or she does not participate in the plan. These contract provisions, which confuse the parties, are unfair to both providers and patients.

To resolve these issues, **plans that use automatically renewing contracts, or have rented part or all of another network, should provide notice to the provider (at least 60 days in advance of the notice termination period) that the contract is about to renew or that their services are about to be rented to another network and that failure to terminate by the deadline will result in contract renewal.** Requiring carriers to notify participants of the termination period will help to keep reported network numbers more accurate. The requirement that carriers report claims submissions will also help to identify potential problems described above where the carrier and the provider have different views as to whether or not the provider is participating in the network.

Thank you in advance for your consideration, and we hope these comments are beneficial to the VA as the Department works to facilitate the establishment of access standards. The APA looks forward to working with the Department of Veterans Affairs to implement provisions included in the VA MISSION Act to ensure veterans and their families have access to high-quality mental health services. Please contact Kristin Kroeger, APA Chief of Policy Programs, and Partnerships, at [KKroeger@psych.org](mailto:KKroeger@psych.org) if you have questions and/or would like additional information.

Sincerely,

A handwritten signature in black ink that reads "Saul Levin, M.D., M.P.A." in a cursive style.

Saul Levin, M.D., M.P.A.  
CEO and Medical Director