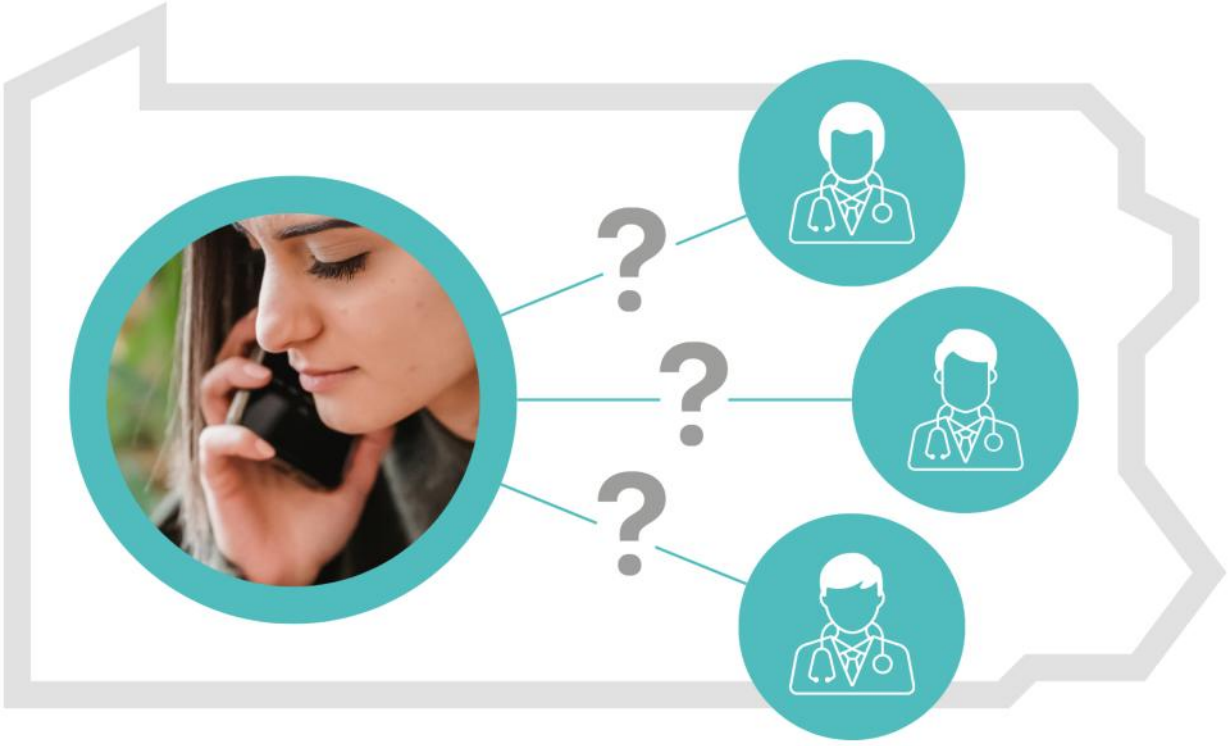
Healthcare Provider Networks Inadequate to Serve All

Causes and Solutions in Pennsylvania



PHAN

PENNSYLVANIA DEVELOPMENTAL DISABILITIES COUNCIL

Contents

Introduction

Across Pennsylvania, people are struggling to get necessary appointments with healthcare providers. Many call through long lists of doctors provided by insurance plans without finding an appointment. They are placed on waiting lists for months or even years. Some drive for multiple hours to see their doctors.

According to the Government Accountability Office's 2022 report on oversight of provider networks: "A provider network can be inadequate if the network has an insufficient number of providers or facilities to provide care to health plan enrollees. Inadequate networks can affect enrollees' ability to access care in a reasonably timely manner."[1] This report explores many of the ways in which people have had trouble accessing care in a reasonably timely manner. It also looks at the nature and scope of network adequacy problems and what the Commonwealth of Pennsylvania can do to fix these problems.

The PA Insurance Department monitors network adequacy in all state-regulated employer plans, and individual Pennie plans, and it shares responsibility with the PA Department of Human Services for Medicaid plans. These agencies should make sure health plans include enough healthcare providers in their networks so that plan members can get appointments and other services without unreasonable delays. However, out-of-date regulations that constrain oversight by regulators allow substantial access issues to go unaddressed.

Because many people in different communities have been unable to access care in a reasonably timely manner, Pennsylvania should update the definitions of and regulations on network adequacy, identify inadequate networks, and ensure health plans expand access to timely care.

How Network Adequacy Became One of PHAN's Key Issues

The work of the PA Health Access Network (PHAN) on network adequacy grew from our Rural Healthcare Access Project, an initiative funded by a grant from the PA Developmental Disabilities Council to improve access to healthcare for people with disabilities in rural Pennsylvania.

Beginning in 2019, PHAN community organizers set out to document the biggest and most common barriers to healthcare access faced by people with disabilities in rural Pennsylvania. We conducted 17 listening sessions across 10 rural counties and had individual conversations with over 500 community members, partner organizations, and healthcare providers.[2]

Network adequacy is a health plan's ability to deliver promised benefits such as doctors' services, inpatient and outpatient hospital care, prescription drug coverage, care for pregnancy and childbirth, and mental and behavioral health services. Health plans must provide reasonable access to a sufficient number of in-network providers and services included under the terms of the contract.

[1] https://www.gao.gov/assets/gao-23-105642.pdf

[2] Read more about the Rural Healthcare Access Project here: https://pahealthaccess.org/rural-access-report/

Grace D.
Lackawanna County
Grace has a disability due to an overdose of anesthesia during surgery and a botched hernia operation. She had to go to several different doctors to address these issues, including a colonoscopy and an obstetric surgeon. She had to wait 3 to 6 months for these appointments. "By the time you get there you will probably be six feet underground. … Some things could be prevented if those appointments weren't that long to wait." These additional complications created thousands of dollars in medical debt and also caused her to miss work. Grace is Native American and Hispanic and reported witnessing and directly experiencing racism in medical settings in which people of color were treated rudely, harassed, or even refused treatment by white healthcare staff.

Sara A.
Montgomery County
"My family relies on multiple specialists to keep us healthy. However, we have found huge barriers for continuity of care. … One of my children sat on a waiting list for appropriate mental health care for 6 years until they aged out and never got the care they needed despite me fighting hard and utilizing all resources available to me. I just tried to make an appointment for a new specialist for myself. The earliest appointment with a doctor I could get was February 2023 (8 months away at time of writing). I made the appointment at the end of June 2022. This is the average we are seeing. Specialists are scheduling into mid-2023 at this point."

Community listening session in Sunbury, PA.

Among the issues reported in these conversations, several common experiences stood out:

- Calling through long lists of doctors provided by insurance plans without finding an appointment
- Waiting months, even years, for appointments
- Driving for multiple hours each way to appointments

Delving deeper into these issues, a common root cause emerged: too few doctors and other healthcare providers in the networks offered by health plans.

Moreover, it became clear that network adequacy problems were not unique to people with disabilities in rural Pennsylvania. They also affected non-disabled people as well as people living in more urban areas of the state. Furthermore, these issues were being reported by people with different insurance types, including Medicaid, Pennie plans, and private insurance.

For people who are already facing healthcare access barriers, including people with low income, seniors, children, people with disabilities, LGBTQ+ people, people of color, those living in rural communities, and those with serious, chronic or complex health conditions, inadequate networks can make it almost impossible to access necessary care.

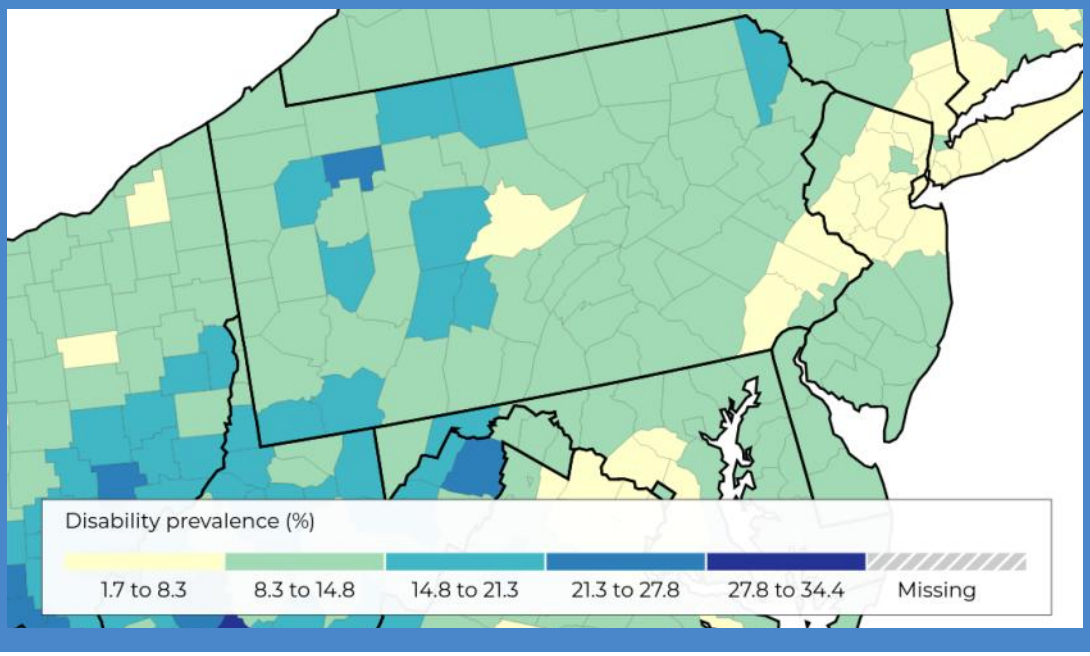
Network Adequacy, Disability, and Rural Communities

In rural Pennsylvania, the percentage of people with disabilities is higher than the state average.[3] Inadequate networks disproportionately affect everyone who lives in rural communities, although people with disabilities may be affected more.

Healthcare infrastructure in rural Pennsylvania is already suffering. Five rural Pennsylvania hospitals have closed since 2005.[4] In rural counties, there is one primary care doctor for every 1,700 residents, compared to the state average of one for every 1,200.[5] Telemedicine is often discussed as a solution to thinning provider networks in rural areas. However, telemedicine is inappropriate for many types of healthcare services and gaps in rural telecommunications infrastructure may prevent telemedicine from being used.

There are also additional barriers that affect the disability community specifically. These include access to specialty care, such as sedation dentistry, physical accessibility of healthcare sites, and availability of Hoyer lifts and other special equipment. People who are blind, deaf, or have other sensory impairments often have trouble getting healthcare providers to set up communication devices and/or getting written material in accessible formats. People with disabilities utilize paratransit more frequently than non-disabled people and may have mobility issues that require special accommodations.

In addition, instances were reported in which people with disabilities were ignored, misdiagnosed, treated superficially, or in the most extreme cases denied life-saving care because of their disability. Finding healthcare providers that take the time to ask questions, learn from feedback and adjust their approach is an additional limiting factor that further narrows the choices of healthcare providers in already thin rural provider networks.



[3] https://www.mathematica.org/dataviz/state-disability-maps
[4] https://www.inquirer.com/news/rural-hospital-healthcare-berwick-emergency-sharma-20230405.html
[5] https://www.countyhealthrankings.org/app/pennsylvania/2021/measure/factors/4/data

Lack of access to healthcare providers is often discussed as a shortage of available doctors and other professionals. However, the failure of health plans to contract with an adequate number of providers to meet the needs of their members must also be considered as a root cause of inadequate networks. Even when workforce shortages are taken into consideration, plans must be more diligent in contracting with an adequate number of providers. Healthcare providers have reported plans denying their applications to join a network despite meeting the stated qualifications and having numerous plan members in the local community who would like to be patients of that provider (see story below).

Dr. Valerie Domenici, Clinical Psychologist
Cumberland County

Dr. Domenici is one of many healthcare providers who have reported problems joining a network. Speaking about one health plan, "They seem to have completely shut down their provider credentialing department for mental health. New providers have not been able to join the network for years. They simply do not reply to applications, fail to send contracts to approved providers, or fail to fully execute those contracts for up to a year after they are signed. Mental health access for subscribers is going to suffer substantially as provider practices get full and no new providers can be added to the network. This has been going on at least 5 years." Dr. Domenici went on to say that her colleagues had resorted to messaging the health plan's executives on Facebook and Twitter to get their attention.

A Massive Network Failure

The following example describes a case in which a health plan allegedly defrauded the Commonwealth of Pennsylvania by falsifying their network.

In 2017, Carol Wessner, a former employee of Aetna Better Health PA, filed a lawsuit alleging that Aetna had defrauded the Commonwealth.

At the time, Aetna provided managed care to hundreds of thousands of Medicaid members. As a quality management consultant, Wessner was tasked with checking that pediatric patients were receiving timely wellness screenings and services. Noticing that Aetna's screening rates were lower than the state average, Wessner began calling pediatricians in Aetna's network that had low annual visit rates. She found that many of the providers listed in Aetna's network did not have a contract with Aetna, were out-of-state, retired, or dead. In some cases, instead of being assigned to pediatricians, children were being sent to vascular surgeons. Infants and males were being sent to adult gynecologists. Wessner says that she was terminated shortly after sharing this discovery with her superiors.[6]

Aetna's incentive for this misrepresentation, according to the lawsuit, was to decrease the number of services it had to pay for while still being paid the same per member fee by the state, thus increasing its revenue.[7]

Aetna's contracts to provide Medicaid services were not renewed by the PA Department of Human Services in 2022. Aetna denies the allegations and the lawsuit is ongoing. However, this incident raises several questions about whether other plans are doing their due diligence in assembling adequate provider networks and whether the Pennsylvania state government is able to effectively regulate and monitor these networks.

Health plans seek to maximize revenue and minimize expenditures, part of which means paying for as little treatment as possible. State oversight is therefore crucial for ensuring that access to care is not eroded by health plans' revenue maximizing behavior. However, as will be discussed in the "State Oversight" section (pg. 12), institutions and practices that were put in place to ensure adequate networks have many shortcomings.

State oversight is crucial for ensuring that **access to care** is not eroded by health plans' **revenue maximizing behavior.**

[6] https://www.healthcaredive.com/news/former-employee-blows-whistle-on-aetnas-fraudulent-provider-network-that-l/606612/
[7] https://www.inquirer.com/business/health/aetna-medicaid-whistleblower-fraud-network-philadelphia-20211110.html

Network Adequacy Regulations in Pennsylvania

Problems with network adequacy in Pennsylvania are partially due to shortcomings in existing state regulations.

Pennsylvania regulations on network adequacy have remained stagnant for the past 20 years, although the healthcare industry has changed and expanded significantly. These changes include the adoption of the Affordable Care Act, increased availability of narrow and tiered networks, and a diversification of plan types.

The Bureau of Managed Care within the PA Insurance Department is responsible for ensuring that all managed care health plans comply with state regulations on network adequacy.

All state-regulated managed care plans (commercial and publicly-funded) must comply with Act 68 of 1998 and with the regulations set forth in 28 PA Code § 9.679, issued in 2001:

> *A plan shall provide for at least 90% of its enrollees in each county in its service area, access to covered services that are within 20 miles or 30 minutes travel from an enrollee's residence or work in a county designated as a metropolitan statistical area (MSA) by the Federal Census Bureau, and within 45 miles or 60 minutes travel from an enrollee's residence or work in any other county.*

In addition to meeting these time and distance standards, health plans must also: report yearly on their efforts to maintain adequate networks, keep provider directories updated, ensure accessibility for people with disabilities, notify the PA Insurance Department when network changes occur, and make arrangements when in-network care is not available, such as allowing the member to see an out-of-network provider at no extra cost.[8] These regulations apply to Medicaid, Pennie plans, and state-regulated employer plans.[9]

The PA Department of Human Services also monitors network adequacy of Medicaid health plans. In order to provide Medicaid services, a health plan must sign a contract with the state. In addition to time and distance standards, these contracts mandate minimum provider to enrollee ratios for primary care physicians (PCPs) of at least one full-time equivalent PCP for every 1,000 enrollees, as well as maximum wait times to appointments that adjust for emergency, urgent, and routine care.[10]

However, despite all of these protections, many communities across the state are struggling with access and unable to get the care they need.

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[8] http://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/028/chapter9/s9.679.html

[9] Medicare is not covered under these regulations and is federally regulated. Federally regulated employer plans (ERISA) are also not regulated by the state. However, many employers use a third-party administrator that primarily offers state-regulated plans. For consistency, the administrator often uses state regulated plans as a template, but this is by custom is not required.

[10] https://www.dhs.pa.gov/HealthChoices/HC-Services/Documents/HC%20Agreement%202021.pdf

Scope of the Problem

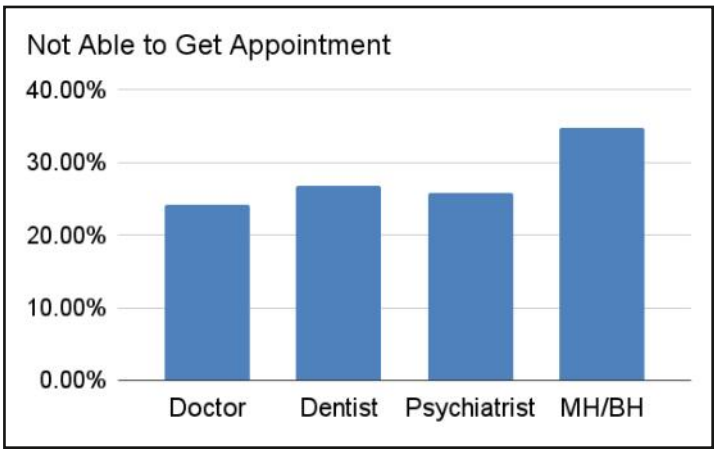
This section summarizes evidence of inadequate networks collected by PHAN and other organizations in Pennsylvania as well as national trends.

PHAN receives hundreds of calls each month from Pennsylvania residents seeking help with healthcare. Over the past two years, PHAN has held 61 listening sessions in 36 counties. The common theme from these conversations is that Pennsylvania residents are struggling to get the care they need.

PHAN also collected 146 comments on network adequacy in July 2022 during a public comment period by the PA Insurance Department. Commenters reported barriers to getting an appointment with the following provider types (from most to least frequently reported):

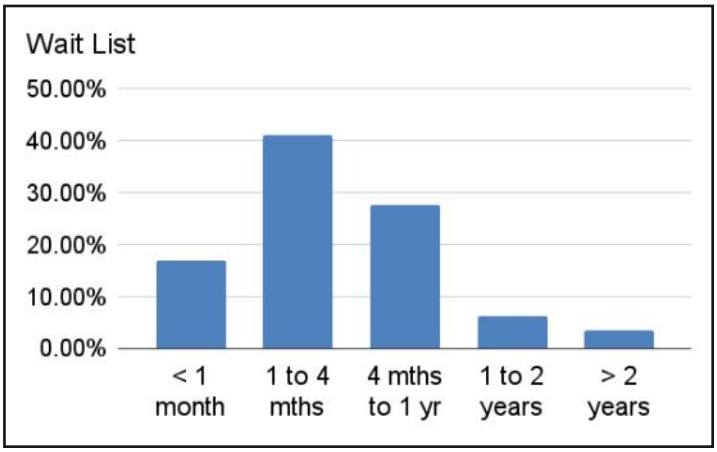
- psychiatrist (20 commenters),
- therapist (17 commenters),
- dentist (15 commenters),
- other mental or behavioral health services (12 commenters),
- primary care physician (12 commenters),
- neurologist (11 commenters),
- dermatologist (10 commenters),
- optometrist (7 commenters),
- not specified (42 commenters).

Comments are available on our interactive map https://pahealthaccess.org/story-map/



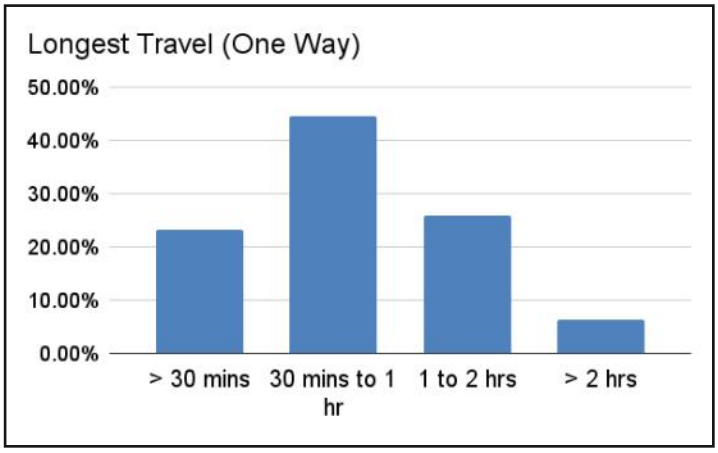
In a survey of 112 Pennsylvania residents conducted by PHAN in January 2022:

- **24% of participants were unable to get an appointment with a primary care doctor.**
- **27% were unable to see a dentist.**
- **26% were unable to see a psychiatrist.**
- **36% were unable to see a mental health or behavioral health professional.**

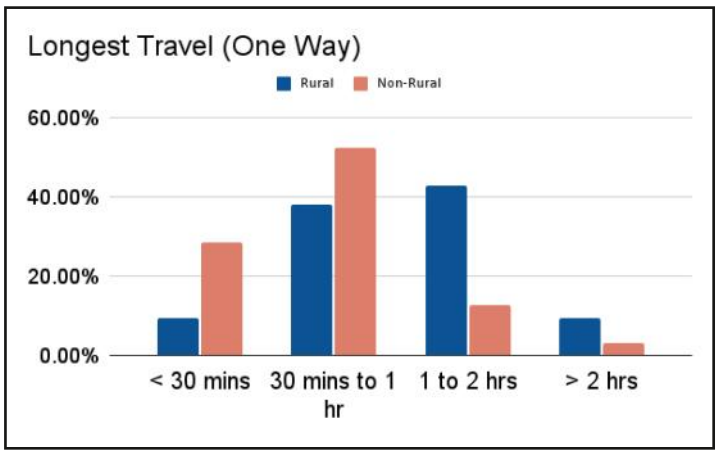


Nearly 38% of participants reported being placed on a waitlist for an appointment for longer than 4 months, with 10% reporting wait lists longer than 1 year, and 4% reporting wait lists longer than 2 years.

A full 32% of survey participants reported one way travel times to appointments longer than 1 hour, with 6% reporting one way travel longer than 2 hours. This is well beyond the minimum time and distance standards discussed in the previous section.



These results were more extreme in rural areas, with 52% of rural participants reporting a one way travel time of over an hour and 10% reporting a travel time of over 2 hours. By comparison, only 16% of non-rural participants reported a travel time of over an hour and only 3% reported a travel time of over 2 hours.



A similar survey by BeHeard BeHealthy PA, in August 2022 with 278 participants found that 52% of those surveyed reported being placed on a waitlist for longer than 30 days when scheduling their most recent appointment, while 43% reported having to wait more than 3 months. In addition, 1 in 5 stated that their condition had worsened due to these delays.[11]

Looking at healthcare provider availability, a 2022 national study by the March of Dimes identified maternity care deserts in 6 counties in Pennsylvania. A maternity care desert is "any county without a hospital or birth center offering obstetric care and without any obstetric providers." An additional 13 Pennsylvania counties had "moderate access". According to the report, "moderate access to care is defined as living in a county with access to few hospitals/birth centers or obstetricians and an adequate proportion of women without health insurance coverage (less than 10% of women)."[12]

[11] https://lookerstudio.google.com/u/0/reporting/77e8cebd-4101-4521-9c65-814df917a8f7/page/qgR
[12] https://www.marchofdimes.org/sites/default/files/2022-10/2022_Maternity_Care_Report.pdf

Providers who are listed as part of a network but do not actually see a meaningful number of members of that network can also give a false impression of network adequacy. Another study by the PA Coalition for Oral Health defined a "meaningful provider" as a healthcare provider (in this case dentists, both general and specialist) that bills over $10,000 in patient care to the plan in a year. The study found that of the total number of dentists participating in Medicaid in Pennsylvania in 2021, only 87.9% were billing over $10,000 a year. This suggests that the remaining dentists were being claimed by the Medicaid plans as part of their networks, but were not actually seeing a substantial number of Medicaid patients. In some regions, the percentage of these "meaningful providers" was as low as 68.4%.[13] In addition, multiple health plans each claiming the full capacity of the same provider without acknowledging that that provider's capacity is divided among multiple networks can also camouflage deficits in a network.

All of these data align with trends nationally and in other states. A 2022 study by Health Affairs of Medicaid plans in Kansas, Louisiana, Michigan, and Tennessee found that care was highly concentrated among a small percentage of providers listed in network directories of managed care plans:

- **Only 25% of primary care providers were providing 86% of care.**
- **Only 25% of specialists were providing 75% of care.**
- **One-third of providers saw fewer than ten patients with Medicaid a year.**[14]

Studies of provider directories used by health plans consistently show an alarming number of inaccuracies. A 2022 study by Health Affairs of Oregon's Medicaid Managed Care program found that 58.2% of network directory listings were 'phantom providers' who did not actually see Medicaid patients.[15]

The term 'phantom provider' can sometimes be morbidly literal, as instances of deceased providers appearing in these listings have been documented. A network containing a large number of phantom providers is referred to in the media as an illusory or ghost network.

As seen in the Aetna lawsuit, assessments of network adequacy based on inaccurate listings can create the false impression that the network contains many more providers than it actually does. A 2023 study by the American Journal of Managed Care concerning the accuracy of provider directories for mental health providers in California found that a large percentage of psychiatrists were incorrectly listed across multiple insurance types: 32.3% in commercial plans, 34.8% in individual plans, and 35.4% in Medicaid.[16]

[13] https://paoralhealth.org/wp-content/uploads/2023/01/PCOH-23-Workforce_full-report.pdf
[14] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2021.01747
[15] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.00052
[16] https://www.ajmc.com/view/provider-directory-inaccuracy-and-timely-access-for-mental-health-care

Debra D.
Franklin County

Debra (top) and her daughter Shanna (bottom right) had not been able to see a dentist for over a year, not since they started receiving Medicaid. Debra was provided a list of dentists by her Medicaid health plan. However, all of the dentists on the list either did not accept that health plan, were retired, were a pediatric dentist, or had a waitlist for over a year. The wait list seemed to never go down, it was still a year when she called a year later. Many of the dentists were far away from her home, but would not see her even if she had been willing to make the journey.

When Debra and a PHAN organizer called her Medicaid health plan, they weren't aware that the dentists on the list were no longer in their network. They blamed the dentists for not updating their information, even though this is clearly defined as the plan's responsibility in state regulation. The health plan would only allow Debra to file a complaint against the dentists, not against the plan for providing her with incorrect information.

PHAN also assisted Debra in filing a complaint to the PA Insurance Department. However, the PA Insurance Department responded that the complaint could not be acted upon because a formal complaint had not been filed with the health plan, only an "informal dissatisfaction request". Debra clearly stated that she wanted to file a formal complaint when talking to the plan.

State Oversight

This section looks at the ways in which network adequacy monitoring and enforcement by state agencies can allow problems with network adequacy to go unchecked.

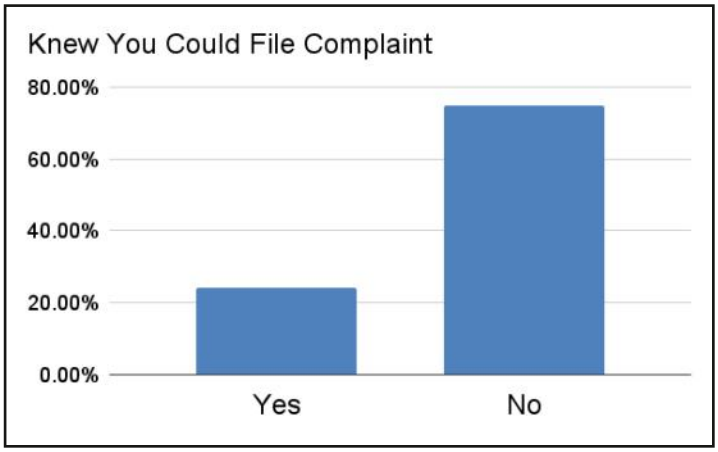
PHAN has spoken with key staff in both the PA Department of Human Services and the PA Insurance Department about their practices around monitoring and enforcing network adequacy. Health plans must regularly submit reports on network adequacy to the PA Insurance Department and the PA Department of Human Services. These reports include maps showing the locations of all members and whether they have access within the required time and distance standards for each provider type.

However, time and distance standards are not a direct measure of access, nor does compliance with these standards guarantee access. Time and distance standards only measure the location and density of healthcare providers relative to the location of the homes and workplaces of plan members. Having a provider in your area does not mean you can access that provider. Providers can be heavily backlogged or not accepting new patients. Additionally, a single provider is likely to participate in multiple networks. If that provider can only see 100 patients, yet is counted in 5 different networks as able to see 100 patients, that provider cannot possibly see 500 patients. Plans can therefore present a network that appears adequate on paper, but has substantial access issues in reality.

Actual availability of appointments and wait times are better indications of network adequacy because they can measure access based on direct communication with providers and patients. Health plans are currently not required to report on how quickly providers are able to schedule a visit when a member calls for an appointment. As noted above, wait times of 6 months or much longer are common.

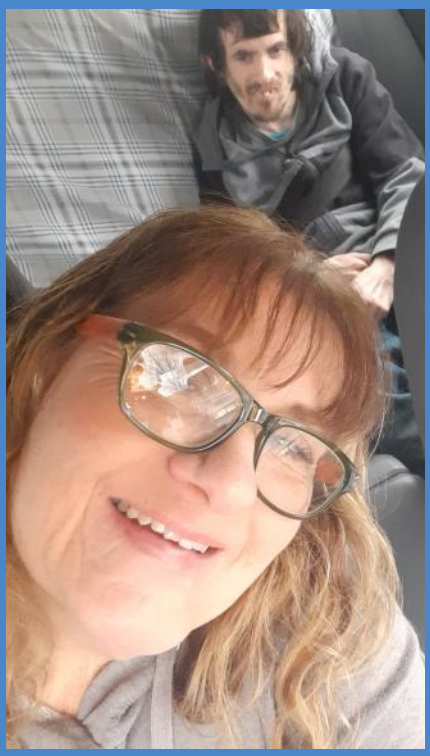
Most importantly, while the data in the reports is subject to analysis by state agencies, the validity of the data is not verified. In other words, state agencies effectively assume that health plans are submitting accurate data.

The other channel by which the PA Department of Human Services and the PA Insurance Department learn about network adequacy issues is through member complaints, a feedback mechanism that also has many shortcomings. DHS has no mechanism for receiving complaints directly. Members can only go through their plans.



When participants in PHAN's network adequacy survey were asked if they were aware they could file complaints, 75% indicated they were not aware they could file a complaint with a state regulator to help resolve issues with finding and accessing a healthcare professional that fits their needs.

Yvonne H.
Perry County



Yvonne's son Luke is 32 and has an intellectual disability, cerebral palsy, and autism spectrum disorder. They live in a rural area and Luke's family states he was not able to get enough in-home support from the local providers.

Yvonne eventually arranged for Luke to be placed in a residential care home in a different county, a situation she had been struggling to avoid for six years. Although Luke is doing well in the new location, and Yvonne is happy with the quality of care Luke is receiving, the fact that Luke is far away is a strain on the family.

"It's been a real struggle for me since Luke was placed in residential. It's an hour and twenty minute drive one way. This makes keeping him an active part of family life very hard. I feel he is very cut off from what has always been familiar to him."

Because the issue was not resolved, PHAN assisted Yvonne in filing a complaint to the PA Department of Human Services. However, instead of looking at the availability of providers in Perry County, the Department investigated the quality of care in Luke's residential care home.

Not wanting to subject the care home staff to further scrutiny and not wanting Luke to lose his current behavior support staff by being moved into a different program, Yvonne chose not to pursue the complaint.

"The way I see it is that there is an issue with people filing complaints because they have to weigh the pros and cons. The complaint numbers can be low, but actual issues aren't getting addressed."

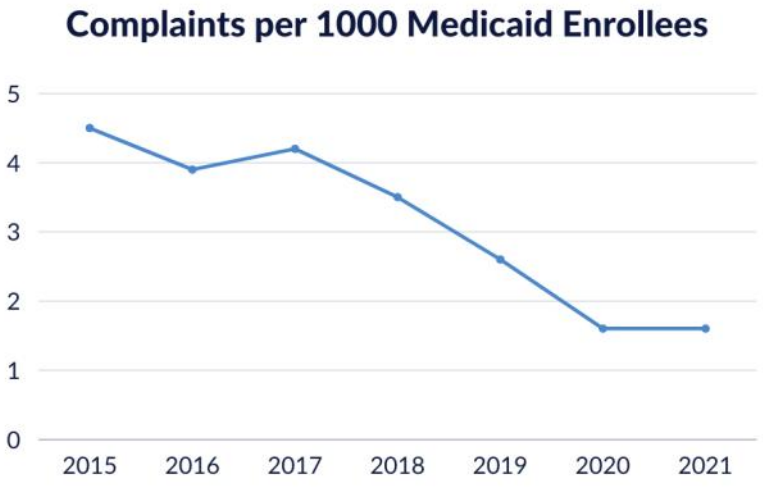
Our assessment, based on experience and conversations with department representatives, is that both of these state agencies typically work to resolve the issue for the particular individual filing the complaint. The PA Department of Human Services and the PA Insurance Department have each told PHAN that they would investigate a health plan if they received enough complaints regarding that plan's network. However, it is unclear if this type of investigation has actually occurred and if there is a standard as to how many complaints would trigger a wider review.

Complicating matters is the fact that there are not currently definitions and guidance for categorizing and reporting on network adequacy-related complaints. In 2022, PHAN obtained records of all complaints received by the PA Department of Human Services from 2015-2021 as part of a right-to-know request. These records show that a complaint can be categorized using a number of codes including "Lack of Providers" and "Wait Times", both of which could be indicative of a network adequacy issue. However, PHAN's request for "any and all records of analyses, summaries, or reports concerning complaints" only returned documents where the various types of complaints were counted for each plan. This suggests that the PA Department of Human Services does not aggregate and track complaints in a way that would reveal deficiencies in a provider network.

The chart on this page shows the number of complaints received per 1,000 Medicaid enrollees, according to records obtained through the right-to-know request.

The data shows that only a small percentage of enrollees file complaints. The obscurity of the complaints process combined with PHAN's observations of broader network problems with health plans leads us to conclude that the number of documented complaints is too small to be an accurate representation of the actual prevalence of problems.

Exclusive reliance on complaints sets up a regulatory process that assumes everything is functioning as it should unless someone complains. This is especially problematic given questionable accessibility and validity of complaints processes as a regulatory tool. Included in the response to PHAN's right-to-know request were requests for exceptions from network adequacy standards in circumstances where a plan was not able to provide complete coverage. The plans cited the absence of complaints as evidence that no one was being denied access to care. However, **absence of evidence is not evidence of absence**, and access issues may persist undetected.



Solutions

This section presents a detailed description of how state regulations could be updated and improved to better protect health plan members and hold plans accountable for deficits in their networks.

Existing law gives the PA Insurance Commissioner authority to modify regulations to guarantee "the availability and accessibility of adequate health care providers in a timely manner, which enables enrollees to have access to quality care and continuity of health care services."[17] The PA Department of Human Services can also improve their standards by amending their managed care contracts.

PHAN along with our partner organizations recommend regulators take action in the following areas:

Improve the Complaints Process

Given that complaints are the main mechanism by which state agencies are alerted to network adequacy problems, the PA Insurance Department and the PA Department of Human Services should each develop a plan to better educate plan members about their rights and how to file complaints. This will ensure complaints are representative of members' experience. Communities that have experienced historic access barriers, including people with disabilities, rural communities, communities of color, and communities with high health needs, including those with behavioral health needs, should be a priority.

In addition, regulators should create definitions and guidance for categorizing and reporting on network adequacy-related complaints and ensure that health plans accurately identify network adequacy issues and report them as such to regulators.

Update Quantitative Standards

Even with increased awareness of the complaints process, complaints should only be one component of a multifaceted, proactive strategy for monitoring health plan networks. Because time and distance standards are not a direct measure of access, plans can present a network that appears adequate on paper, but has substantial access issues in reality. A flexible and diverse array of quantitative measures is therefore necessary.

To ensure data is meaningful, actionable, and representative of members' experiences, regulators should add additional standards to their analyses of health plans' network adequacy performance. Each of these standards should be determined for each provider type in a given network and area.

Updated Time and Distance Standards
Current standards do not ensure timely access to care for all members, especially for rural areas. Rural community members PHAN has spoken with have emphasized that a 45 mile drive to an appointment can be extremely burdensome, especially if an individual has frequent appointments or difficulty finding transportation. Conversely, federal standards take into consideration differences in geography and service type.

[17] https://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=1998&sessInd=0&act=68

New Patient Acceptance
Actual availability of appointments is a better indication of network adequacy than time and distance standards because it measures access directly rather than inferring it.

Wait Times to Schedule Appointments
Tracking wait times to appointments also measures access directly.

Ratios of Providers to Enrollees in an Identified Area
Although this metric is, like time and distance standards, not a direct measure of access, it can be helpful when comparing provider density across areas and across plans.

Protect High-risk and Vulnerable Populations

Regulators should ensure that networks include providers that treat high risk populations such that health plans do not avoid risk by excluding providers who serve these populations from their network. This includes a) providers who are geographically located in areas that contain high-risk populations, b) providers who specialize in treating high risk populations, and/or c) providers who actually treat high-risk populations. High-risk populations can include low-income people, seniors, children, people of color, people with disabilities, LGBTQ+ people, people with limited access to transportation, people living in rural areas of the state, and people with serious, chronic or complex health conditions. The National Association of Insurance Commissioners has published model legislation on network adequacy which includes these types of protections.[18]

Regulators should also commit to directly engaging with impacted communities so that new regulations will be shaped based on the experience of those who are most impacted by them.

Improve Monitoring and Enforcement

Regulators should verify the accuracy and integrity of the data they receive from health plans.

Regulators should develop a plan to proactively monitor network adequacy. Other states have done so using a variety of strategies, including market conduct exams, "secret shopper" programs, and surveys of consumers and providers. Regulators should also utilize the following metrics to monitor health plan performance:

Number of In-Network Providers as a Percentage of Available Providers
This statistic helps show whether a plan is doing due diligence in contracting with available providers in a given area in cases where plans claim they were not able to recruit a sufficient number of providers into their network due to workforce shortages.

Amounts Billed, Number of Members Seen, and Number of Networks Joined by Each Provider
This information would identify providers who inflate the number of providers in a network without contributing meaningfully to the treatment of members. This would also address the issue of provider capacity being incorrectly multiplied across multiple networks.

Complaints and Requests for Out-of-Network Care
Both of these are possible indications that a plan is not providing an adequate network.

[18] https://content.naic.org/sites/default/files/model-law-074.pdf

Reduce Administrative Barriers for Providers

The burden on healthcare providers of having to provide detailed documentation to the state and/or the health plan when joining a network and filing claims can cost them time with patients and even prevent them from joining a network. This is especially relevant in Medicaid networks, where lower reimbursement rates may already discourage providers from joining. The PA Insurance Department as well as the PA Department of Human Services can work to make it easier for healthcare providers to join networks and get paid for the care they provide by streamlining and standardizing these administrative processes.

Increase Transparency

Much of the dialogue between the PA Department of Human Services, the PA Insurance Department, and the health plans they regulate is unavailable to the public. This includes reports submitted by health plans, complaints data, and cases where health plans were sanctioned by the state. The absence of this information means the public cannot assess whether the plan they purchase will provide sufficient access to quality providers.

Complaints data, utilization reviews, out-of-network care, grievances, and other information should be analyzed and presented to consumers. Making this information easily accessible through websites and other channels would provide valuable information on plan performance to consumers and advocates.

Regulators should also publish regular reports on network adequacy and how they monitor and evaluate member access. This would give members additional confidence that their plans' networks are free of misrepresentation.

Conclusion

We all trust health plans to provide us with vital, often lifesaving care. When a health plan fails to provide a robust network of providers, they are breaking that trust. If not addressed through improved regulations, network adequacy problems will only worsen. In the four years since PHAN conducted listening sessions in rural counties, issues with finding providers have only become more widespread and urgent.

While Pennsylvania network adequacy regulations have stagnated for the past 20 years, the federal government and other states have recognized and responded to the need for regulation of provider networks. PHAN and our partner organizations believe it is time for Pennsylvania to follow suit. Doing so will greatly improve access to healthcare for everyone living in the Commonwealth of Pennsylvania.

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