December 12, 2019

Al Redmer, Jr.
Commissioner
Maryland Insurance Administration
200 St. Paul Place
Baltimore, MD 21202

Re: <u>Measurement of Wait Times</u>

Dear Commissioner Redmer:

Thank you for the opportunity to submit comments on network adequacy standards for commercial health insurance carriers. The Community Behavioral Health Association of Maryland (CBH) is the professional organization for community-based programs offering mental health and substance use disorder treatment. Our 60 members serve nearly three-quarters of the 290,000 individuals using Maryland's public behavioral health system.

Our members provide a quality service and are highly motivated to contract with commercial carriers. However, few have done so, largely due to a combination of low reimbursement rates and credentialing barriers.

Despite passage of the federal parity law (the Mental Health Parity and Addiction Equity Act), there is overwhelming evidence of disparate treatment of behavioral health by insurance carriers, and unfortunately Maryland stands out as one of the worst offenders. Two reports by Milliman, Inc. – one released in December of 2017 (analyzing claims during calendar years 2013 through 2015) and one in November of 2019 (analyzing claims for calendar years 2016 and 2017) – found that reliance on out-of-network providers for outpatient mental health and substance use disorder treatment was significantly higher than that for primary care, and has not improved from the time of the initial report's release to the most recent report. Maryland's disparity in use of out-of-network office visits for behavioral health versus primary care was the 4th worst in the nation in 2017, and nearly twice the national average, and the 2017 reimbursement in Maryland for psychiatrists was 18% less than other physicians for the same billing codes, relative to the Medicare allowed amount.

Clearly there is a need for oversight of carriers in their compliance with the federal parity act, and measuring of wait times is an appropriate proxy for compliance with Maryland's network adequacy standards. We offer the following comments as follow up to last month's discussion of Maryland's

network adequacy regulations, particularly as they apply to the tracking of wait times.

While discussing COMAR 31.10.44.05 on Nov. 5, a carrier raised the point that it is hard to measure and comply with wait time standards when the member seeking treatment may request a particular type of provider (e.g., male therapist, practitioner trained in trauma informed care, etc.), which might add to the wait time. She noted that this concern is of particular relevance in behavioral health treatment due to the very personal nature of the therapeutic interaction and the need to form a trusting relationship between client and practitioner.

Facility Credentialing Addresses Wait-Time Barriers

We agree with the carrier's points and respond by arguing that facility credentialing of outpatient mental health centers (OMHCs) will assist in providing more immediate access for individuals with special needs or requests. OMHCs are designed to provide various disciplines (psychiatrists, licensed social workers, licensed counselors, psychologists, etc.), types of clinicians (males and female clinicians who see adults, children & adolescents, and/or geriatric clients), and specialties (treatment of trauma, serious mental illness, mood disorders, etc.) under one roof. The idea is to utilize a team approach and provide quick access to anyone needing services.

Medicaid allows OMHC providers to internally credential each individual clinician, so there are rarely lags in access for Medicaid recipients since all clinicians working under the OMHC umbrella are credentialed with Medicaid. Commercial carriers, however, require each individual clinician to go through the carriers' credentialing processes, leading to delays and access problems when a clinician leaves the OMHC or in instances where there are specialized requests, such as those mentioned above. CBH members have noted that they are sometimes able to credential their psychiatrists but not the therapists who work together with those prescribers. Clients are then forced to go to two different places for treatment, even if they wish to have their medication management and therapy provided in the same location. It also creates challenges for coordination between the prescriber and therapist, who practice in different locations.

Our providers' internal credentialing processes are thorough. We have been told by carriers that national accrediting bodies will not allow them to "deem" credentialing to providers. However, commercial carriers allow facility credentialing for hospitals, FQHCs, and opioid treatment programs (OTPs). CBH would be happy to share our members' internal credentialing processes with the carriers to ensure that all carrier requirements are met. For purposes of enhancing network adequacy and greater coordination of clinical care we strongly urge that OMHCs be added to the list of provider types that can be credentialed as facilities.

Data Collection of Provider Wait-Time

During the November 5th meeting there was also discussion as to how commercial insurers can track and report data to demonstrate compliance with 2017 network adequacy regulations, including appointment wait times for behavioral health appointments. While CBH understands that this is not a simple effort, it is not an impossible effort, and it is critically important to ensuring that insurer networks have adequate numbers of behavioral health providers to meet member needs.

In Vermont, behavioral health providers formed a provider network, supported by a data warehouse that allows tracking wait-time data. Modeled off of Vermont's work, CBH has undertaken a similar effort. In 2019, CBH launched a provider network and implemented a supporting data warehouse. This is in recognition of the need for quality data for our members to make business decisions; negotiate beneficial contracts with payers; improve quality of care delivery; and better understand and improve patient outcomes.

The CBH data warehouse is being developed with our members who have agreed to adopt standard definitions for data collection and standard processes for data collection and reporting. Currently, the warehouse collects and compares standardized cost data. Implementation of utilization and access data is underway, including patient wait times for service. Standardization will make it possible for CBH to report patient wait times for specific services and specific payers.

CBH members are currently in discussions to finalize the definition and processes to extract relevant data to understand patient wait times for outpatient mental health and substance use disorder services and residential services. While the definition is not finalized, members are considering "wait time" to be the amount of time from the patient initial phone call scheduling an appointment to the time the appointment schedule. No shows and patient requested rescheduling will not be included in the wait time calculation. We are building the infrastructure that will enable members to use this data for internal purposes and to report back to payers and other stakeholders.

I appreciate your attention to these concerns. If you need additional information, do not hesitate to reach out to me at (410) 788-1865.

Sincerely,

Shannon Hall, J.D.
Executive Director