Consumer Health First

Access ▪ Quality ▪ Equity

University of Maryland
Francis King Carey
School of Law

Clinical Law Program
Drug Policy and Public Health Strategies Clinic

May 4, 2017

Lisa Larson
Assistant Director of Regulatory Affairs
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

RE: Proposed Regulations Chapter 44 Network Adequacy

Dear Ms. Larson:

Consumer Health First (CHF), our partners at the University of Maryland Carey School of Law Drug Policy Clinic, and the 23 signatory organizations identified in the attachment to this letter are pleased to submit these comments on the Maryland Insurance Administration's (MIA) proposed network adequacy regulations published on the MIA's website for public comment. These proposed regulations are the culmination of the collaborative process led by the MIA to develop quantitative network adequacy standards as required under HB 1318 enacted during the 2016 Legislative Session. We actively participated in this process and submitted recommendations pertaining to appointment wait times, geographic time/distance standards, essential community providers and the applicability of these quantitative standards to specific health care services and/or providers. Additionally, we commented on the confidentiality standard the MIA should apply to carriers' access plans.

Throughout the public process, we urged the MIA to adopt appointment wait times as one of the quantitative standards included in its network adequacy regulations. As we noted in our previous comments, the National Committee for Quality Assurance (a leading accreditation organization), at least twelve other states, and Kaiser Permanente in its testimony to the MIA, all recognize the importance of this metric. ***We applaud the MIA for including appointment wait time standards in its proposed network adequacy regulations and CHF strongly urges the MIA to retain this important consumer protection in its final regulations***.

While we recommended specific geographic time/distance standards for a wide range of providers, the MIA's proposed regulations include only distance standards. We understand the difficulties in measuring travel times and ***believe distance standards coupled with appointment wait time standards offer meaningful consumer protections, giving consumers confidence that carriers have an adequate network for delivering all health care services covered under each product and plan.***

We urged the MIA to require carriers to include at least 30 percent of the available essential community providers in their networks and to adopt an expanded definition of essential community providers. ***We strongly support the requirement for carriers to include at least 30 percent of the available essential community providers in their networks and to include local health departments, outpatient mental health and community-based substance use disorder programs, and school-based programs (see Definitions below) in the definition of essential community providers.*** We believe these requirements ensure continued access to providers that lower-income consumers rely upon for important health care services. ***We ask the MIA to consider applying this standard separately to outpatient mental health and community-based substance use disorder providers in recognition of the crisis we are facing in combating substance use disorders.*** We also recommend the MIA specify in its final regulations the methodology carriers must use to determine compliance with this metric; ***specifically, the methodology adopted by the Maryland Health Benefit Exchange for 2018.***

During the collaborative process, CHF and its partner organizations recommended that the MIA make information publicly available to consumers regarding the performance of carriers against the network adequacy quantitative standards adopted by the MIA. ***We appreciate the care the MIA has taken in the proposed regulations to allow public disclosure of certain parts of a carrier's access plan by expressly delineating the specific information in a carrier's access plan that is to be considered confidential. With the inclusion of one recommended revision to incorporate federal Parity Act standards, we urge the MIA to preserve this provision in the final regulation and continue to work with stakeholders to develop a meaningful report that consumers may use to evaluate each carrier's network to make an informed choice among available products and plans.***

We respectfully note a waiver process is not contemplated in Maryland's provider panel statute, the MIA's current provider panel regulation, or in the NAIC's Health Benefit Plan Network Access and Adequacy Model Act. All carriers must satisfy the proposed network adequacy quantitative standards to meet their contractual obligations to consumers to provide access to in-network providers authorized to deliver covered services. We believe a waiver process undermines the consumer protections included in these proposed regulations and for this reason ***we strongly urge the MIA to delete .07 Waiver Process.***

In addition to these general comments, CHF offers the following changes to specific provisions in the proposed network adequacy standards.

.02 Definitions

A. Essential Community Provider

The definition of "essential community provider" references an incorrect provision of federal law and does not include all the providers that the Maryland Health Benefit Exchange has designated as essential community providers for 2017 and 2018 EHB-

based plans. The federal statutory reference to "essential community provider" is found in 42 U.S.C. 18031, and school-based programs are also included in the State's definition of essential community providers. To address these two issues, we recommend the definition be revised as follows:

(6) "Essential Community Provider" means a provider, as defined in 42 U.S.C. § 18031, that serves predominantly low-income or medically underserved individuals and local health departments, outpatient mental health and community-based substance use disorder programs and school-based programs.

B. Telemedicine

This year, the General Assembly enacted legislation defining telehealth (see HB 983 Health Insurance – Health Care Services Delivered through Telehealth – Coverage). We would ask the MIA to strike the definition of "Telemedicine" and substitute the following definition:

"Telehealth" has the meaning stated in § 15-139 of the Insurance Article.

We propose to use this definition in a new provision, .04 F. as explained below.

.03 Filing of Access Plans

The proposed regulation does not currently include all statutory provisions pertaining to material changes to an access plan. ***To address this, we propose the following addition:***

B. *(3) The Commissioner may order corrective action if, after review, the access plan is determined not to meet the requirements of this Chapter.*

.04 Geographic Accessibility of Providers

- We respectfully point out that .04 A. (1) does not specify how a carrier should measure the distance specified for each provider while .04 B. (1) does so. Specifically, .04 B. (1) states *"The distances stated in § B(2) shall be measured from the enrollee's location, home or place of employment, from which the enrollee gains eligibility for participation in the staff model HMO plan."* ***We recommend the MIA include this same language in .04 A. (1).***

- We strongly support the inclusive list of providers specified in .04 A (2). However, the Medicare Advantage provider specialty list does not adequately identify providers of substance use disorder services, and, as a result, the most common providers of these services in Maryland are not included in this list. We note that the proposed rule includes at least one service, Applied Behavioral Analysis, that is not on the Medicare Advantage specialty list. ***Therefore, we respectfully request the final regulations include the following specialties with the same distance standards as psychiatrists and psychologists: Licensed Counselors,***

Alcohol and Drug Counselors, and Physicians Certified in Addiction Medicine.

In addition, several facility-based settings provide substantial services in Maryland and should be included in the list with the same standards as outpatient dialysis and physical therapy. They include outpatient substance use and mental health clinics and Opioid Treatment Programs.

- Our health care delivery system increasingly depends upon non-physician providers. In our letter to the MIA dated November 16, 2016, CHF recommended a time/distance standard for advanced practice nurses equivalent to that of primary care physicians. ***We believe advanced practice nurses should be recognized in the final regulations for network adequacy as these professionals are increasingly providing primary care services as well as gynecological and obstetrical services.***

- Essential community providers are addressed in .04 C. The proposed regulations state *"C. Each plan shall have 30 percent of the available essential community providers as part of its provider panel* ***in each of the defined rating areas****."* "Rating areas" is not a defined term in the proposed regulations. In addition to the proposed revision to the definition of essential community providers, **we urge the MIA to define this term.** In addition, the proposed regulation does not identify the methodology for calculating the 30% inclusion standard. ***We recommend that the MIA adopt the standard adopted by the Maryland Health Benefit Exchange applicable to qualified health plans in 2018.***

- While we ***caution that telehealth should not be the only way for a consumer to access needed health care services, its use may be appropriate when there are insufficient providers in an area and request the MIA include the following provision:***

  F. A carrier may use telehealth to meet the requirements set forth in these regulations if the carrier demonstrates to the Commissioner that there are not sufficient numbers of providers in a geographic area to meet the requirements of this section.

- We would be remiss if we did not note the potential applicability of the State Health Plan specified under COMAR 10.24.07-.17 to the geographic standards for inpatient facilities. For example, the current State Health Plan for Facilities Service for Psychiatric and Emergency Services states communities should have access to inpatient psychiatric facilities and inpatient substance disorder services within 30 miles in a metro area and 45 miles within a rural area. Although not updated frequently, these standards are modified based on shifts in access to services and population changes. ***We recommend the MIA request the Maryland Health Care***

Commission provide formal notification of changes in the State Health Plan for the MIA's consideration of its geographic standards.

.08 Confidential Information in Access Plans

The Federal Mental Health Parity and Addiction Equity Act includes requirements for the disclosure of certain information applicable to the development and adequacy of provider networks. *See* 45 C.F.R. § 146.136(c)(4)(ii)(D) and 29 C.F.R. § 2590.712(c)(4)(ii)(D) (network admission standards); Final Rules Under the Paul Wellston and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240, 68246 (Nov. 13, 2013) (identifying network adequacy as an NQTL); 45 C.F.R. § 146.136(d)(3); 29 C.F.R. § 2590.712(d)(3); and 78 Fed. Reg. at 68247-48 and n. 27(disclosure standards). **The Parity Act disclosure requirements explicitly cover the three items that the proposed regulation would deem confidential if requested by a member**. Federal sub-regulatory guidance makes clear that such information cannot be withheld as proprietary. Dept. of Labor and HHS, FAQ 31, Q.9 (April 20, 2016) (emphasis added). Available at: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resourcecenter/faqs/aca-part-31.pdf. ***For this reason, we recommend the following change to .08 A:***

> ***"Except as required under the Mental Health Parity and Addiction Equity Act, the*** *following information that is included in a carrier's access plan shall be considered confidential by the Commissioner:"*

In closing, we ask you to consider our comments as you move forward with finalizing the proposed regulations for network adequacy. We are grateful to the MIA for the opportunity to provide input to this important process. We look forward to continuing to work with you to develop a meaningful report, showing the carriers' performance against the final adopted quantitative standards, that consumers may use to evaluate networks and make informed choices among available products and plans. Thank you for taking the time to consider our recommendations, and please do not hesitate to contact us if you have any questions.

Sincerely,

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Signatory Organizations:

Advocates for Children and Youth

Baltimore City Substance Abuse Directorate

Behavioral Health System Baltimore

Center for Children, Inc.

Community Behavioral Health Association of Maryland

Greater Washington Society for Clinical Social Work

League of Women Voters of Maryland

Licensed Clinical Professional Counselors of Maryland

Maryland Addictions Directors Council

Maryland Affiliate of the American College of Nurse Midwives

Maryland Assembly on School-Based Health Care

Maryland Hospital Association

Maryland Nonprofits

Maryland United for Peace and Justice

Mental Health Association of Maryland

Mid-Atlantic Association of Community Health Centers

Montgomery County Department of Health and Human Services

NAMI Maryland

NARAL Pro-Choice Maryland

National Council on Alcoholism and Drug Dependence-Maryland Chapter

Planned Parenthood of Maryland

Progressive Cheverly Health Committee

Sisters Together And Reaching, Inc.