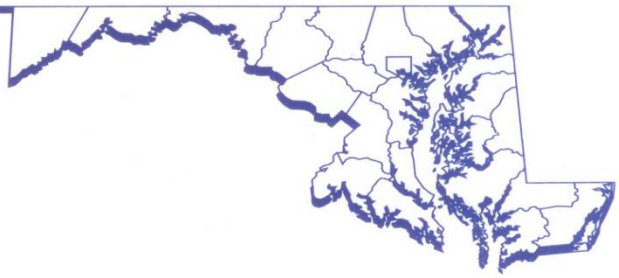
Maryland Association of
COUNTY HEALTH OFFICERS
an affiliate of Maryland Association of Counties, Inc.



MARYLAND Association of COUNTIES

MARYLAND RURAL HEALTH ASSOCIATION

Maryland Insurance Administration
200 St. Paul Place Suite 2700
Baltimore, MD 21202

May 5, 2017

Maryland Insurance Administration Staff,

In response to Title 31 Maryland Insurance Administration Subtitle 10 Health Insurance – General 31.10.44 Network Adequacy:

The Maryland Association of County Health Officers, the Maryland Association of Counties, and the Maryland Rural Health Association strongly recommend amending two sections of the current draft.

1. Section .04 A should add a new subsection (2), and the current subsection (2) should be renumbered as subsection (3), as follows:

Section .04 A ***(2) Each provider panel shall include all willing Local Health Departments in the plan's service area. Carriers shall include behavioral health services when contracting with Local Health Departments***

(3) *Chart of Specialty and Geographic Area Distance Requirements.*

2. Section .04 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.",* should be amended to *"Each plan shall have 30 percent of the available essential community providers**, in addition to Local Health Departments,** as part of its provider panel in each of the defined rating areas."*

Maryland residents in many areas of the state struggle to access health care. This is particularly problematic for those in need of behavioral health services. Nineteen of Maryland's 24 jurisdictions contain U.S. Department of Health and Human Services (HHS)-designated mental health provider shortage areas (MHPSA). The HHS does not formally designate substance use provider shortage areas. However, the Governor's Opioid and Heroin Task Force has demonstrated widespread limitations in access to substance use providers across Maryland.

In 15 Maryland jurisdictions, the local health department (LHD) is the primary or sole provider of mental health care, substance abuse care, or both. Despite the Affordable Care Act's core intent to

expand access to behavioral health care, contracting restrictions imposed by many health insurance companies continue to block LHDs from joining provider networks and impede treatment access to many private insurance enrollees. The designation of local health departments as Essential Community Providers (ECPs) **with the requirement for private carriers to include LHD behavioral health services in every plan's panel** would significantly improve access to care for many across Maryland.

Governor Hogan has made treatment of opioid addiction a priority for Maryland. However, for residents in many areas across the state, substance abuse treatment is inaccessible in part due to the refusal of private carriers to contract with local health departments. Although people have the option of paying for treatment out of pocket, this is a practical barrier for most health insurance enrollees. It also results in a disruption of treatment when someone transitions from Medicaid to a private insurance plan.

The current draft of Title 31 Maryland Insurance Administration Subtitle 10 Health Insurance – General 31.10.44 Network Adequacy only requires that, *"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."* This does not take into account that many ECPs do not provide behavioral health services. As such, these standards are inadequate to meet network adequacy needs in Mental Health Provider Shortage Areas. By definition, even if every provider in a MHPSA were under contract, the geographic area would still not achieve adequacy. Allowing carriers to meet their 30% threshold by contracting with an ECP in a geographic area that provides limited or no behavioral health care, and thereby being able to exclude a LHD with significant behavioral health resources, fails to address health shortage needs of Marylanders.

The lockout of LHDs from provider networks also results in reduced fee collections for each health department. As a result, health department treatment capacity is diminished due to insufficient financial resources to hire more mid-level providers or afford the salary of a psychiatrist. It is much more realistic for LHDs to add providers to their existing practices than to expect new private providers to open offices, especially in the more rural parts of the state. At many health departments, staffing limitations result in waits of 1-3 months to see a psychiatrist or psychiatric nurse practitioner. Such delays can be the difference between the successful transition of an ER patient to stable outpatient care and cycles of preventable re-hospitalizations.

Decreased collections for behavioral health services also results in the inability of LHDs to sufficiently staff treatment locations geographically distributed across their counties. This leads to inadequate access for those with limited transportation or time constraints. Intensive outpatient substance abuse treatment requires sessions 3 days/week. Adding an hour or more for travel to appointments in distant parts of a county requires more time off of work and/or greater need for child care, thereby jeopardizing people's employment or leaving them to choose between treatment and proper supervision for their children. Limiting treatment offices to one location per county also decreases access to the buprenorphine and Vivitrol that are critical to the treatment of opiate abuse for many patients.

Most private carriers have shown that they are unwilling to offer contracts to LHDs. Since LHDs are the key to immediate expansion of access to behavioral health care in the majority of Maryland's jurisdictions, the designation of LHDs as Essential Community Providers **along with the requirement of carriers to contract for behavioral health services from all willing health departments in each plan's service area, are critical to network adequacy**.

During previous discussions held through a Maryland Health Benefits Exchange (MHBE) Network Adequacy Workgroup, some insurance carriers raised concerns about contracting with essential community providers that employed unlicensed staff or did not use electronic billing. These are not concerns when considering LHDs. Health departments employ licensed providers. In addition, LHDs

have years of experience working with insurance carriers. LHDs routinely handle provider-credentialing requirements and bill electronically.

The current impediments for LHDs to contract with many private carriers revolve around the amount of malpractice coverage carried by state health care providers and boilerplate indemnification language contained in the insurers' contracts. Health departments are unable to alter either of these factors. The amount of malpractice coverage is set by state statute. Liability issues are also legislatively fixed. It should be noted that these factors were understood by CareFirst and did not prevent its contracting with LHDs. It should also be noted that United Healthcare agreed to contract for somatic care in select counties despite the presence of the same liability restrictions, but they have been unwilling to offer behavioral health contracts to LHDs.

A primary underlying goal of the MHBE Act of 2012 and the Maryland Health Progress Act of 2013 was to insure continuity of care for individuals transitioning between health plans. The fundamental goal of these Acts is to avoid disruption in treatment following a change in insurance coverage. This insurance "churn" is of greatest concern when historically underserved people transition between Medicaid and private coverage. Treatment disruptions forced by changes in insurance coverage can cause significant harm to patients' health, particularly for those receiving behavioral health care.

The amendments proposed above were approved by the MHBE Board of Directors in 2015. At that time, opinion held that the MHBE had the authority to implement these improvements for Essential Community Provider designations and network requirements. Subsequent to the Board's action but prior to the promulgation of MHBE regulations, legal opinion shifted and decided that regulatory authority rests with the Maryland Insurance Administration. As a result, MACHO, MACo, and the MRHA, with the goal of expanding access to critically needed behavioral health care across all of Maryland, advocate for the **designation of local health departments as ECPs and to require each provider panel for all insurers to include all willing LHDs, including behavioral health services**.

Thank you very much for your consideration,

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