

Network Adequacy: Research and Recommendations

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Maryland Insurance Administration
Network Adequacy Hearing

Presenters

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Agenda

- Background
- Research-based Approach
- Overarching Recommendations
- Mental Health and Substance Abuse Disorder Recommendations
- Access Plan Disclosure
- Monitoring and Reporting
- Q&A

Importance of Quantitative Standards

- Consumers => assurance that the insurance plans they select have the in-network providers they need when they need them
- Regulators => specific standards/tools to measure carriers' networks and enforce network adequacy requirements

Key Standards

- Appointment wait time standards
- Geographic time and distance standards
- Essential Community Providers
- Use of telehealth
- Language interpretation

A Research-Based Approach

- 50-State survey of quantitative standards
 - Appointment wait times
 - Geographic standards: distance and travel time
 - Provider/Enrollee ratios
- Medicare Advantage plans
- Federally Facilitated Marketplace
- NCQA and other accreditation metrics

A Research-Based Approach

- **Key Findings** (research current through Aug. 2016)
 - 23 States + Medicare Advantage have adopted 1 or more metric. 5 others require compliance with NCQA or other national accreditation standard
 - 12 States have wait time standards
 - 21 States + Medicare Advantage have geographic standards
 - 12 both time and distance
 - 7 - distance only
 - 2 - travel time only

A Research-Based Approach

- **Key Findings**

- 11 States + Medicare Advantage have geographic standards that account for population density
 - Urban, Suburban, Rural and similar variations (4 States)
 - Large Metro, Metro, Micro, Rural, CEAC (2 States + Medicare Advantage)
 - Variations based on population, urban and non-urban (5 States)
- 11 States have both wait time and geographic standards
- 9 States + Medicare Advantage have provider/enrollee ratios. 4 others require compliance with NCQA/other accreditation standard

Recommendations - Appointment Wait Times

- Most important metric to consumers
- Ability to get a timely appointment is directly dependent on whether network is sufficient to meet needs of consumers
- Allows consumers to know when they can go out of network

Recommendations - Appointment Wait Times

Recommended Appointment Wait Time Standards for Maryland

| | |
|--|------------------|
| All urgent care | 24 hours |
| Routine primary care | 7 calendar days |
| Preventive visit/well visit | 30 calendar days |
| Non-urgent specialty care | 30 calendar days |
| Non-urgent ancillary care | 30 calendar days |
| Non-urgent mental health and substance use | 7 calendar days |

Recommendations - Geographic Time/Distance

- Requirements for three separate metrics:
 - Geographic regions by county
 - Regions and definitions for Medicare Advantage Plans and 2017 Federally Facilitated Marketplace
 - Large metro, metro, micro, rural, and counties with extreme access consideration (CEAC)
 - Distance from member's residence
 - Travel time from member's residence

Recommendations - Geographic Time/Distance

| Specialty | Large Metro | | Metro | | Micro | |
|---|-------------|-------|-------|-------|-------|-------|
| | Max | Max | Max | Max | Max | Max |
| | Time | Dist. | Time | Dist. | Time | Dist. |
| Primary Care/OB/GYN | 10 | 5 | 15 | 10 | 30 | 20 |
| Dermatology | 20 | 10 | 45 | 30 | 60 | 45 |
| Gastroenterology | 20 | 10 | 45 | 30 | 60 | 45 |
| Alcohol & Drug Counselors/Licensed Clinical Social Workers, Therapists & Counselors | 10 | 5 | 15 | 10 | 30 | 20 |
| Orthopedic Surgery | 20 | 10 | 30 | 20 | 50 | 35 |
| Psychiatry/Psychology | 20 | 10 | 30 | 20 | 50 | 35 |
| Pulmonology | 20 | 10 | 45 | 30 | 60 | 45 |
| Rheumatology | 30 | 15 | 60 | 40 | 100 | 75 |
| PT/ST/OT/Chiro. | 20 | 10 | 45 | 30 | 80 | 60 |

Essential Community Providers

- Expand definition of ECP to include Local Health Departments, school-based programs, and outpatient mental health and community-based SUD programs
- Require carriers to contract with at least 30% of available ECP's in service area
- Require carriers to offer contracts in good faith to: all available Indian Health Care Providers; any willing Health Department; and, at least one ECP in each ECP category

Telehealth and Other Technology

- Support use of technology to enhance access to care
- Must not be the only way for a consumer to access care
- Used for convenience and benefit of consumer, not the provider or carrier
- Standards must comply with the Mental Health Parity and Addiction Equity Act

Language Interpretation

- Essential to reducing health disparities
- Has potential to save costs to health system:
 - Ensuring patients can communicate with providers
 - Arrive more quickly at a diagnosis
 - Fully understand treatment plans
- Require carriers to disclose steps to ensure providers provide access to language assistance

Mental Health & Substance Use Disorder Recommendations

- Goal and Principles
 - Respond to Maryland’s opioid overdose crisis and mental health service need
 - Source of health care for persons with mental health and substance use disorders
 - Comply with Mental Health Parity and Addiction Equity Act
- NCQA Behavioral Health Standard
- Other State Standards
 - Wait times - 5 States have standards for MH/SUD providers; 5 States require compliance with NCQA
 - Geographic standards - 10 States and Medicare Advantage have standards for MH/SUD providers

Mental Health & Substance Use Disorder Recommendations

- Wait Time
 - Urgent care - 24 hours
 - Non-urgent care - 7 calendar days
- Geographic
 - Designate prescribers and non-prescribers consistent with Maryland's provider community
 - Counseling services (non-prescribers) consistent with primary care metrics
 - Track outpatient clinics and opioid treatment programs consistent with metrics for outpatient medical facility services

Mental Health & Substance Use Disorder Recommendations

- Essential Community Providers
 - Outpatient mental health and substance use disorder programs designated ECP for all plans
 - Contracts with 30% of available mental health and substance use disorder programs

Access Plan Disclosure

- **NAIC Policy Guidance**
 - Presumption – public information
 - Identify specific provisions, if any, as proprietary
- **State Standards**
 - 7 States address disclosure of access plans
 - No designation of protected portions of plan
 - Authority given to insurance department to designate portions, at request of carrier, to protect proprietary or competitive information

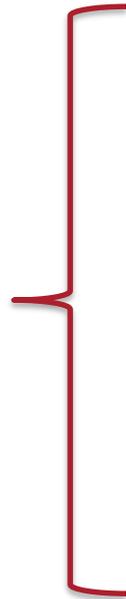
Access Plan Disclosure

- **Statutory Standards**

- **Public Information Act – Confidential commercial or financial information (§ 4-335). Non-disclosure if:**
 - Impairs government’s ability to get information in future or causes substantial harm to competitive position
 - Carrier has burden of demonstrating “substantial harm”
- **Mental Health Parity and Addiction Equity Act**
 - Access Plan is an instrument under which plan is established and operated
 - Access plan standards are non-quantitative treatment limitations
 - HHS/DOL guidance – NQTL information cannot be withheld based on claim as proprietary or commercially valuable
- **Parity Act standards apply if portion protected under PIA**

Reporting and Oversight

Transparency



- Annual reporting
- Publicly available
- Public reporting

Reporting & Oversight - Recommendations

- To monitor compliance with time/distance standards:
 - Use template developed by CMS for the Federally Facilitated Marketplace, incorporating all specialists
- For wait time standards:
 - Follow California's method of requiring carriers to demonstrate adequacy

Reporting & Oversight - Recommendations

- Create comprehensive website to:
 - Explain network adequacy regulations
 - Post all compliance reporting documents
 - Clearly state rights of consumers
 - Provide clear direction to consumers on where to go for assistance

See California's Department of Managed Health Care: <http://www.dmhc.ca.gov/>

Signatory Organizations & Individuals

Organizations

Advocates for Children and Youth
American Association on Health & Disability
Anne Arundel County Department of Health
Baltimore City Substance Abuse Directorate
Behavioral Health System Baltimore
Center for Addiction Medicine
Center for Children, Inc.
Community Behavioral Health Assoc. of Maryland
Disability Rights Maryland
FIRN
Greater Washington Society for Clinical Social Work
IBR/REACH Health Services
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 Assoc. of Behavioral Health Authorities, Inc.
Maryland Coalition of Families
Maryland Hospital Association

Maryland Nonprofits
Maryland Nurses Association
Maryland Occupational Therapy Association
Maryland Assoc. for the Treatment of Opioid Dependence
Montgomery Co. Dept. of Health and Human Services
NAMI Maryland (and 12 County Chapters)
NARAL Pro-Choice Maryland
National Council on Alcoholism and Drug Dependence-
Maryland Chapter
Open Society Institute-Baltimore
Planned Parenthood of Maryland
Powell Recovery Center
Primary Care Coalition
Progressive Cheverly Health Committee
Public Justice Center
Sisters Together And Reaching, Inc.

Individuals

Mike Davidson
Kerri Preul

Resources

1. HB 1318:
http://mgaleg.maryland.gov/2016RS/chapters_noln/Ch_309_hb1318E.pdf
2. Maryland Insurance Administration Network Adequacy
Website:<http://insurance.maryland.gov/Consumer/Pages/Network-Adequacy-Regulations-Information.aspx>
3. Consumer Health First Network Adequacy Web Page, including our Network Adequacy Report: <http://www.consumerhealthfirst.org/network-adequacy/>
4. Mental Health Association of Maryland Report - *Access to Psychiatrists in 2014 Qualified Health Plans*: <https://mhamd.org/wp-content/uploads/2014/01/2014-QHP-Psychiatric-Network-Adequacy-Report.pdf>
5. Network Adequacy 101: An Explainer
<http://familiesusa.org/product/network-adequacy-101-explainer>
6. Health Benefit Plan Network Access and Adequacy Model Act:
<http://www.naic.org/store/free/MDL-74.pdf>

Questions?