Consumer Health First
Access • Quality • Equity

Nancy Grodin
Deputy Insurance Commissioner
Maryland Insurance Administration

August 19, 2016

Dear Ms. Grodin:

Consumer Health First (CHF) appreciates the opportunity to work collaboratively with the Maryland Insurance Administration to develop regulations specifying quantitative standards for health insurance carrier networks. This will give consumers the assurance they deserve that every health insurance carrier has a network capable of delivering the care they need when and where they need it, irrespective of whether the consumer is healthy and only needs preventive care, is chronically ill, or has an acute condition.

At the hearings held to date, CHF has provided oral testimony that included general observations about quantitative standards as well as specific quantitative standards for time and distance and appointment wait times. Our remarks to date are summarized below for your use and reference. We offer the following caveat: our remarks are based upon our on-going research at the state and national level. However, as the hearing process continues and you begin the drafting process, we anticipate continuing to refine and further define our recommendations. Therefore, this should not be considered our final word on these complex issues.

We also wish to comment on the process that you have undertaken to develop the regulations. While we very much appreciate your efforts to make this both effective and efficient, we continue to believe that it would be useful to you if there were a greater opportunity for dialogue between all stakeholders. Therefore, one suggestion we have is that all carriers be required to provide substantive comments on quantitative standards for carrier networks and that those be posted. This would allow other stakeholders to review these and provide thoughtful comments in response. And, of course, the reverse would be true as well.

*General Observations*

The accreditation organizations, NCQA and URAC, have been engaged in evaluating carriers' network adequacy for decades. NCQA notes "Determining whether a health plan provides adequate member access to care is a function of multiple indicators" and has long required carriers to establish: (1) provider-enrollee ratios for primary care, high-volume medical specialists and high-volume behavioral health specialists; (2) standards for geographic distribution of each type of primary care providers, high-volume medical specialists, and high-volume behavioral health specialists; and (3) appointment wait times for primary care and behavioral health.

We know from the Maryland Health Care Commission's report cards that all major carriers in the state have NCQA accreditation. Thus, it is reasonable to assume that

each of these carriers has already established quantitative criteria for provider-enrollee ratios, geographic distribution, and appointment wait times and yet this criteria, to date, has not been shared publicly through this hearing process. CHF urges the MIA to use its regulatory power to identify the criteria used by carriers presently so that the public has an opportunity to assess whether the commonly used criteria and the methods employed to determine whether the criteria have been met are: (1) sufficient to assure all consumers that every carrier has a network capable of delivering the care they need when they need it; and (2) should form the basis for the MIA's quantitative criteria.

*Time/Distance Standards*

CHF has reviewed the quantitative standards for time and distance developed by the Federal government for the Medicare Advantage program as well as a number of states. The Medicare Advantage program offers the most comprehensive quantitative standard for time and distance. The Medicare Advantage program recognizes patterns of care vary by geography and divides counties into one of five categories based on population density: large metro, metro, micro, rural, and counties with extreme access considerations (CEAC). Furthermore, the Medicare Advantage program recognizes consumer access to providers varies by specialty and has grouped specialties into one of three general categories: primary care, common specialists, and other specialists. This approach generally satisfies the overarching goal to give consumers access to the care they need when they need it, yet recognizes that there are differences in the availability of providers by specialty and by geography. **We recommend adopting the approach of dividing counties into geographic categories, as outlined above. However, we feel that the grouping of specialists into three general categories is insufficient, particularly regarding behavioral health specialists. CHF and our partner organizations continue to research best practices and will make specific recommendations in a separate letter once our research is complete.**

*Appointment Wait Times*

The importance of appointment wait times is well recognized by accreditation organizations and a number of states for evaluating network adequacy when coupled with other quantitative standards such as time and distance. As the California Department of Managed Health Care noted in this year's *Timely Access Report* "the true test of whether a health plan is meeting its commitments is whether a health plan enrollee can get an appointment with their provider within a reasonable period of time."

Maryland's carriers are currently assessing wait time access under NCQA requirements. For many years, NCQA has required carriers to adhere to the following appointment wait times for behavioral health services and now requires carriers to assess adherence to these specific appointment times by four different types of behavioral health providers:

| NCQA Behavioral Health Appointment Wait Time Standards | |
|---|---|
| Care for a non-life-threatening emergency | 6 hours |
| Urgent Care | 48 hours |
| Routine office visit | 10 business days |

NCQA also requires carriers to establish appointment wait times for regular and routine primary care appointments, urgent care appointments, and after hours care and to begin collecting data on accessibility to high volume specialty care which must include OB/GYNs and oncologists.

Despite the advances made by NCQA, its standards fall short for Maryland consumers. Except for behavioral health, the appointment wait time standards may not be consistent across carriers, are certainly not transparent and, if adopted by Maryland, would make it impossible to assess and compare compliance across carriers.

According to research conducted by the University of Maryland Carey School of Law Drug Policy Clinic, ten states have established appointment wait time standards for non-HMO plans: Arizona, California, Colorado, Maine, Montana, New Jersey, New Mexico, Texas, Vermont, and Washington. There are commonalities, but not uniformity, among these states. For example:

a. Five states (Colorado, New Jersey, Montana, Texas and Vermont) have a 24-hour standard for urgent care while four states (California, Maine, New Mexico, and Washington) have 48 hours.

b. The standard for an appointment with a primary care provider ranges from 7 days (Colorado), to 10 business days (California, Maine and Washington) to 15 days (Arizona).

c. Two states have a 60-day standard for specialty care (Arizona and Colorado) while two states have 15 business days (California and Washington) and one (Maine) has 30 days.

After reviewing these states, we conclude that **California and Colorado offer standards that, combined, create the right framework for Maryland**.

| California Appointment Wait Time Standards | |
|---|---|
| Urgent Care (including medical, mental health, and substance use disorder) | No preauthorization required: 48 hours<br>With preauthorization required: 96 hours |
| Routine Primary Care | 10 business days |
| Non-urgent Physician Specialist (includes psychiatrist) | 15 business days |
| Non-urgent Ancillary services | 15 business days |
| Non-urgent Non-physician Mental Health / Substance Use Disorder provider | 10 business days |

| Colorado Appointment Wait Time Standards | |
|---|---|
| Urgent Care (including medical, mental health, and substance use disorder) | 24 hours |
| Routine Primary Care | 7 calendar days |
| Preventive Visit / Well Visit | 30 calendar days |
| Specialty Care | 60 calendar days |
| Non-urgent Mental Health / Substance Use Disorder provider | 7 calendar days |

*Annual Reporting Process*

We also wish to highlight the importance of monitoring compliance with the standards through an annual reporting process. Such a process offers greater protections for consumers who have the assurance of effective oversight of the carriers to ensure that networks are truly adequate. At the same time, it protects the carriers from any potential for adverse selection by those with expensive health conditions who would gravitate to plans based upon the robustness of their network. The result would be greater equity with plan selection based upon health management and administrative efficiency rather than disparities in networks.

Two states, California and Colorado, have reporting processes that we recommend the MIA follow for Maryland. We recommend California's reporting process for appointment wait times and Colorado's for geographic time and distance standards.

California has a common methodology each carrier must use to measure its performance against the established standard for designated providers. In 2012, carriers first submitted detailed annual reports to the Department of Managed Care to demonstrate compliance with the appointment wait time standards. After the first submission, the Department found that carriers used a variety of methods to measure compliance, making it impossible to compare carriers' performance. California now requires carriers to assess compliance through a standardized audit method or a provider survey, publicly available on the Department of Managed Health Care's website. It is our understanding most carriers have elected to use the provider survey developed by the state and to administer this survey in accordance with the state's specifications. Last year, carriers administered the survey to primary care physicians, dermatologists, cardiologists, allergists, psychiatrists, and adolescent and child psychiatrists. Each year, the Department of Managed Health Care publishes on its website the final findings from its review so consumers can assess carriers' compliance with the appointment wait time standards. Given the extensive work done in California, **we recommend that the MIA adopt California's annual reporting process for wait time standards**.

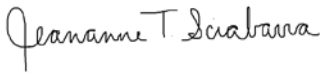
Regarding reporting on compliance with geographic time and distance standards, **we believe that Maryland should adopt the annual reporting process now required in Colorado**, as outlined in Bulletin B-4.90 and pending regulations.

*Standards Specific to Behavioral Health Services*

An important part of this process will be determining how the standards will differ based on type of provider, including behavioral health providers. To that end, our partner organizations, including the Mental Health Association of Maryland and the University of Maryland Carey School of Law Drug Policy Clinic, will be submitting separate recommendations specific to mental health and substance use disorder services.

In closing, CHF looks forward to continuing to work with you to ensure timely access to health care services for all consumers.

Sincerely,



Jeananne T. Sciabarra, Executive Director, Consumer Health First
jsciabarra@consumerhealthfirst.org
August 19, 2016