Board of Directors

Brad S. Karp
Chairman

Mary Beth Forshaw
Vice Chair

Eric D. Balber
Elizabeth Bartholet
Suzanne B. Cusack
Stephen M. Cutler
Jason Flom
Alexis Gadsden
Doug Liman
Elaine H. Mandelbaum
Kamran Masood
Michael Meltsner
Marc L. Miller
Mark C. Morril
Mary E. Mulligan
Debra Pantin
Elizabeth M. Sacksteder
Sharon L. Schneier
Ed Shaw
John J. Suydam
James Yates
Richard Zabel

Founding Chairman

Arthur L. Liman
From 1973 to 1997

Executive Staff

Paul N. Samuels
Director and President

Anita R. Marton
Deputy Director and Vice President

Tracie Gardner
Associate Director

Joseph N. Thompson
Chief Financial Officer

Sally Friedman
Legal Director

Gabrielle de la Gueronniere
Director of Policy

Robert B. Levy
Director of Development

Roberta Meyers
Director, National H.I.R.E. Network

Sebastian Solomon
Director of New York State Policy

Ellen Weber
Vice President for Health Initiatives

Abigail Woodworth
Director of Communications and Strategy

August 14, 2017

Lisa Larson
Regulations Manager
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202

Re: Notice of Proposed Action
Network Adequacy 31.10.44 (17-199-P)

Dear Ms. Larson:

Thank you for the opportunity to submit comments on the Maryland Insurance Administration's proposed regulations regarding quantitative standards for network adequacy in private carrier networks. The following comments are submitted by the Legal Action Center, a law and policy organization that works to end discrimination against persons with substance use disorders, HIV/AIDs or criminal histories, and the thirteen (13) undersigned organizations that seek to ensure equitable access to substance use disorder and mental health services in Maryland's commercial market. Our organizations have participated actively in the MIA's process for developing network adequacy standards and, working with Consumer Health First and the Drug Policy Clinic, University of Maryland Carey School of Law, have provided comments on the MIA's draft proposed regulation in May 2017. The following comments address the rule's proposed standards that are particularly important for the delivery of substance use disorder and mental health services.

We appreciate the steps the MIA has taken to develop quantitative standards for network adequacy and to ensure greater consumer protection as they seek to access health services through network providers. We support the MIA's proposed adoption of appointment wait time standards as one of the key quantitative standards for measuring network adequacy, and we appreciate the strong requirements for demonstrating satisfaction of this metric for substance use and mental health treatment. We also support the inclusion of standards for essential community providers and the use of telehealth services to satisfy waiting time standards when clinically appropriate and elected by the enrollee. We urge the MIA to retain these standards in the final rule.

We are disappointed, however, that the proposed standards will weaken the geographical distance standards, compared to those presented in the draft proposed rule by using the State Department of Planning geographical area designations (urban, suburban and rural) that appear to be sub-county designations as opposed to the Medicare Advantage geographical areas which are based on county-wide areas. We urge the MIA to adopt the Medicare Advantage standards.

New York
225 Varick Street New York, New York 10014
Phone: 212-243-1313 Fax: 212-675-0286
E-mail: lacinfo@lac.org • Web : www.lac.org

Washington
810 1st Street, NE, Suite 200, Washington, DC 20002
Phone: 202-544-5478 Fax: 202-544-5712

In addition, our May comments on the proposed rule urged the MIA to address several standards that undermined the development of strong network adequacy standards, including: (1) removal of the network adequacy waiver option; (2) inclusion of specific provider and facility types that better track the delivery of substance use disorder and mental health services; and (3) adjustment of the confidentiality provision to ensure compliance with the Mental Health Parity and Addiction Equity Act (Parity Act). The proposed rule does not adopt these requested revisions. We renew our request that the final rule contain these critical consumer protections.

I. Definitions: § 31.10.44.02

A. Urgent Care § B(25)

The urgent care definition is framed in terms of "physical and mental health conditions" without reference to "substance use disorders." To ensure that substance use disorders are incorporated into this standard, we urge the MIA to either insert the term "or substance use disorders" after the term "mental health condition" in both 25(a) and (b) or to substitute the term "behavioral health" for "mental health" in both subsections. The term "behavioral health" is defined in the proposed rule to include both mental health and substance use disorder conditions.

B. Waiting Time § B(26)

The proposed rule would remove a key sentence that had been included in the draft definition of this term: "*Waiting time includes the time for obtaining authorization from the carrier or the carrier's participating providers for the appointment.*" This qualifier is important from the enrollee's perspective because it better defines the timing of access to care. It is particularly important for persons who seek mental health and substance use disorder care because carriers impose prior authorization requirements more frequently for behavioral health benefits than for medical benefits and often require more detailed submissions of information. We also note that prior authorization is often required for urgent care services and should be incorporated into the timeline for appointment wait times.

We urge the MIA to include this sentence in the definition of "waiting time" in the final rule.

II. Travel Distance Standards: § 31.10.44.04

The proposed rule contains two significant modifications to the draft rule that will undermine the establishment of strong network adequacy standards under this metric and will make tracking and monitoring of networks far more difficult for enrollees. In addition, the proposed list of provider types and facilities does not identify critical providers of substance use disorder and mental health services. As detailed below, the MIA has identified significant gaps in carrier networks in geographical regions across Maryland through two market conduct surveys conducted over the past three years. Those findings demonstrate the need to track with greater specificity the practitioners and facilities that provide critical substance use and mental health services.

A. Designation of Geographical Areas § A(4)

In contrast to the draft rule that adopted the Medicare Advantage plan geographical regions, as applicable in Maryland (large metro, metro, micro and rural), the proposed rule adopts a census designation of urban, suburban and rural. The Medicare Advantage model offers greater transparency for consumers because: (1) the Centers for Medicare & Medicaid Services has identified the designation for each Maryland jurisdiction (available at https://www.cms.gov/Medicare/MedicareAdvantage/MedicareAdvantageApps/Downloads/CY2017_MA_HSD_Reference_File.zip (Tab Minimum Provider #s);[1] and (2) each county constitutes a single geographical area. We have not been able to locate a Department of Planning list that identifies the state's jurisdictions under the urban/ suburban/rural designations, and it appears that most counties will contain multiple geographical areas. Based on the Medicare Advantage geographical areas, six counties in Maryland are designated "micro" areas – Caroline, Dorchester, Kent, Queen Anne's, Somerset, and Talbot – and geographical distance standards would be weaker for enrollees in these counties if they are designated "rural" areas by the Department of Planning.

Even with a detailed listing of jurisdictions by geographical area, enrollees will be hard pressed to track the appropriate travel distance standards and determine whether the carrier is meeting the required standards. We can easily envision a situation in which a carrier will have multiple travel distance standards in a single county and will miscalculate the required number of providers required to satisfy the travel distance standard.

We oppose the proposed geographical area designations and urge the MIA to adopt the Medicare Advantage plan geographical designations, as proposed in the draft rule. To the extent the MIA retains the proposed designations, we request that the MIA post a list of the state's urban, suburban and rural geographical areas/regions on an annual basis and the rules by which a carrier must demonstrate that it has appropriately calculated each of the distance standards.

B. Identification of Substance Use and Mental Health Practitioners and Facilities § A(4)

The proposed rule, like the draft rule, requires tracking of four specific provider/facility types that offer mental health or substance use treatment: licensed clinical social worker, psychiatry, psychology and inpatient psychiatric facility. In comments submitted during the workgroup sessions and on the draft proposal, we strongly recommended that the list be expanded to include the provider and facility types that offer these services in Maryland. As noted previously, Medicare does not cover a wide range of substance use disorder services, resulting in significant limitations with the use of the Medicare Advantage provider list for this purpose. The most common providers of substance use disorder services in Maryland, including community-based substance use disorder programs and opioid treatment programs (OTPs), are not included in the proposed chart. Significant levels of community-based services are also provided by licensed professional counselors and community mental health centers.

[1] Under the CMS geographical designations, Garrett County alone meets the standard for a rural area and six counties (Caroline, Dorchester, Kent, Queen Anne's, Somerset and Talbot) meet the definition of micro. Three jurisdictions, Baltimore City, Montgomery and Prince George's Counties meet the definition of large metro and the remaining counties are metro.

Over the past three years, the MIA has gathered solid evidence through market conduct surveys that carriers do not have sufficient network providers for the delivery of substance use disorder and mental health services. The MIA's June 30, 2017 summary of its second market survey found that, for some carriers, in-network opioid treatment facilities (OTPs) do not exist in six (6) counties and that inpatient hospitals, inpatient-non-hospital facilities or intensive outpatient treatment programs for opioid use disorders do not exist in four (4) counties.[2] The MIA also found significant gaps in network providers of bi-polar disorder services in inpatient or residential and non-hospital settings: eleven (11) counties lacked in-network non-hospital services, and seven (7) counties lacked in-network inpatient or residential services.[3] These data demonstrate the abundant need to track carrier networks for all providers of substance use disorder and mental health treatment.

Explicit tracking is also essential to address Maryland's opioid crisis. In 2015, the Lt. Governor's Opioid Task Force concluded that carrier networks did not include sufficient numbers of substance use disorder providers and recommended strategies to both incentivize carriers to expand their provider networks and ensure enrollees had the benefit of the coverage they purchased. Lt. Gov., Heroin & Opioid Emergency Task Force: Final Report, at 6, Pt. 3 (Dec. 1, 2015). The MIA's market surveys reveal that the problem has not been resolved and support tracking of network adequacy in this area.

We urge the MIA to add the following providers and facilities to the chart in § .04.A(4): **Licensed Counselors, Alcohol and Drug Counselors, Physicians Certified in Addiction Medicine, Opioid Treatment Programs and outpatient substance use disorder and mental health clinics.** These providers should be available under the same distance standards as licensed social workers, psychologists and psychiatrists.

III. Appointment Waiting Time Standards: § 31.10.44.05

We support the waiting time standards in the proposed rule and the requirement that carriers meet these standards for at least 95% of the enrollees covered under the health benefit plans. We urge the MIA to retain these standards which are the best metric to ensure timely access to care. The proposed wait time standards for substance use disorder and mental health treatment are particularly important to address the need for in-network providers to address our state's escalating opioid crisis that has devastated families across the state and of all socio-economic groups.

We note one inconsistency between the standard for demonstrating compliance in § .05 and the reporting requirement for waiting times in § 31.10.44.09.A(2)(a). The sufficiency standard

[2] For one or more of three carriers (Aetna, Cigna and Kaiser), in-network OTPs do not exist in Calvert, Charles, St. Mary's, Allegany, Garrett and Washington Counties, and in-network, inpatient or residential facilities or intensive outpatient treatment for opioid use disorders do not exist in Garrett, Queen Anne's and Worcester Counties. Letter from Al Redmer, Commissioner, to Senator Thomas McLain Middleton, at 4 n. 2 and 3 (June 30, 2017).

[3] For one or more of three carriers (Aetna, Cigna and Kaiser), in-network non-hospital providers of bi-polar disorder treatment do not exist in Calvert, Caroline, Charles, Kent, Dorchester, Queen Anne's, Somerset, St. Mary's, Wicomico, Worcester and Talbot Counties, and in-network, inpatient or residential services do not exist in Charles, Garrett, Kent, Queen Anne's, Somerset, Talbot and Worcester Counties. Letter from Al Redmer, Commissioner, to Senator Thomas McLain Middleton, at 4 n. 2 and 3 (June 30, 2017).

under § A(1) – 95% of ***enrollees covered under the plan*** – does not measure the same element as that set out in the reporting requirement under § 31.10.44.09.A(2)(a), which identifies the percentage of ***appointments*** for which the carrier met the waiting time standards. The relevant data point is the percentage of appointments that the carrier's network made within the appointment waiting time standards for enrollees who sought the specific service (as opposed to the total number of enrollees who use the provider panel).

To avoid confusion, we request that the two standards be conformed, and that § .05.A(1) be revised to conform to the standard in § .09. We request the following clarifying language (capitals and underlined):

> (1) Subject to §B of this regulation, each carrier's provider panel shall meet the waiting time standards listed in §C of this regulation for at least 95 percent of the enrollees covered under health benefit plans [that use that provider panel] WHO REQUEST AN APPOINTMENT FOR THE SERVICES DESIGNATED IN § .05C.

IV. Waiver Request Standards: § 31.10.44.07

As noted in the comments on the draft rule submitted by Consumer Health First and the Drug Policy Clinic, we strongly oppose the availability of a network adequacy waiver and particularly one that would allow a carrier to request a waiver annually without necessarily correcting on-going deficiencies. We note that 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. **We, therefore, urge the MIA to delete §.07.**

To the extent this provision is retained, we urge the MIA to limit the number of waivers that a carrier may receive rather than permit the granting of sequential annual waivers. We know from the MIA's market conduct investigations under the Mental Health Parity and Addiction Equity Act that carriers can address deficiencies in their networks for substance use disorder and mental health providers using a range of strategies that include more targeted outreach and by responding to reimbursement rate and other contracting barriers.

To this point, we also urge the MIA include a provision that was in the draft rule but removed in the current proposed standard. The draft regulation would have required the carrier, when seeking a waiver request, to provide a copy of its request form to any provider named in the request. *See* Draft Rule § .07.C(2). (A modified notification could be developed to the extent the carrier seeks to ensure confidentiality of certain information.) This notification requirement would provide a reasonable check on the carrier's representations and enable to providers to raise concerns about the carrier's contracting efforts.[4]

[4] We note that the proposed rule also removes language that would have required, for failed contract efforts, that the carrier's contracts offer reasonable terms. Taken together, the MIA will have no ability to determine whether a waiver request that is based on the provider's refusal to contract with carriers or inability to reach agreement is grounded in unreasonable contract terms.

V. Confidential Information in Access Plans: § 31.10.44.08.

As previously set out in comments submitted by the Drug Policy Clinic during the workgroup sessions and in comments we submitted to the draft proposed rule, the proposed confidentiality standards contained in § .08.A are inconsistent with the federal disclosure standards for network adequacy under the federal Mental Health Parity and Addiction Equity Act. The Parity Act requires the disclosure of the carrier's processes, strategies, evidentiary standards and other factors that it used to build its provider network and to evaluate the adequacy of its 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 are non-quantitative treatment limitations); Final Rules Under the Paul Wellstone 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.

To reconcile, the proposed standard with federal law, we recommend the following change to § .08 A (new text underlined and in capital letters):

> "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:"

VI. Network Adequacy Access Plan Executive Summary Form: § 31.10.44.09

We support the requirement that carriers submit a summary of their network sufficiency results for each provider panel and that the Executive Summary Form be a public document. We request that the reporting tool be revised in two ways.

First, for the travel distance standards, we request that, in addition to the percentages requested in § A(1)(a), the carrier also report the total number network providers by category (denominator) and the number for which the carrier met the distance standards (numerator). The total numbers will provide enrollees with a better understanding of the scope of the carrier's network. We request that § A(1)(a) be revised as follows:

> (a) List the TOTAL NUMBER AND percentage of the participating providers, by primary care provider and specialty provider type, for which the carrier met the travel distance standards listed for Regulation .04 of this chapter, in the following format:

Second, in reporting the results for appointment wait times, we request that carriers be required to report their results separately for non-urgent mental health and substance use disorder services. The chart contained in § A(2)(a) could be interpreted as collapsing the two conditions into a single data point. It is critical to have accurate data on network adequacy for both conditions, which cannot be achieved without separate reporting.

Thank you for considering our views. Please contact me at eweber@lac.org or 202-544-5478 Ext. 307 if you have any questions.

Sincerely,

Ellen M. Weber
Vice President for Health Initiatives

Baltimore City Substance Abuse Directorate

Center for Addiction Medicine, Inc.

Community Behavioral Health Association of Maryland

Cornerstone Montgomery, Inc.

Hope House Treatment Center

Institutes for Behavior Resources, Inc.

Licensed Clinical Professional Counselors of Maryland

Maryland Association for the Treatment of Opioid Dependence

Maryland Coalition of Families

Maryland Hospital Association

Mental Health Association of Maryland

National Council on Alcoholism and Drug Dependence-Maryland

Wells House, Inc.