December 19, 2019

Al Redmer, Jr.
Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202

Dear Commissioner Redmer,

Thank you for the opportunity to provide comments in connection with the Maryland Insurance Administration's review of the Maryland network adequacy regulations, COMAR § 31.10.44. I am writing on behalf of the Legal Action Center and the undersigned members of the Maryland Parity Coalition. The Center is a law and policy organization that fights discrimination against individuals with histories of substance use disorders, HIV/AIDS and criminal justice histories. The Center participated actively in the 2017 network adequacy rule-making process and has subsequently evaluated carrier compliance with the regulatory standards. We also lead the Maryland Parity Coalition, whose work has focused on ensuring that carriers comply with the Mental Health Parity and Addiction Equity Act (Parity Act) in the development of their provider networks and all other plan features.

The Center and the undersigned organizations and individuals appreciate the MIA's efforts to strengthen enforcement of the network adequacy standards to ensure that consumers have timely access to network providers for all benefits. We are particularly concerned about network gaps for providers of mental health (MH) and substance use disorder (SUD) services, as documented in both the 2018 and 2019 carrier submissions and the orders issued by the MIA to address carrier network practices that violate the Parity Act. The 2019 report by Milliman, *Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement* (Nov. 19, 2019), supplements this evidence of significant network gaps for Marylanders seeking MH and SUD treatment. The Milliman report documents that, for Marylanders in 2017, out-of-network (OON) utilization for MH and SUD office visits exceeded OON primary care office visits by 10%; for outpatient facility services, OON utilization for MH and SUD services exceeded medical/surgical services by 3.66%; and, for inpatient facility services, OON utilization for MH and SUD services exceeded medical/surgical services by 9.35%. Maryland is ranked the 4th worst state in the nation for OON utilization for MH and SUD office visits.

As the MIA evaluates revisions to the network adequacy regulations, the undersigned organizations strongly believe that the three quantitative metrics - geographical travel distance, appointment wait time and provider-patient ratio – and the numerical standards

for each metric are on target and should be retained. Revisions to the numerical metrics themselves are premature, pending full disclosure from carriers regarding their efforts to contract with MH and SUD providers and the reasons for non-compliance with the existing metrics. **The goal of our recommendations is to provide greater granularity to assess the availability of MH and SUD providers, based on existing numerical metrics, and provide greater transparency regarding the carriers' efforts to contract with MH and SUD providers and facilities, and ensure that the MIA can assess carrier provider networks for compliance with the Parity Act.**

Several lessons from the two-year implementation effort have guided our recommendations:

- Standardization of the methodology for calculating compliance with the three metrics is necessary to improve enforcement and allow consumers to compare carrier networks.
- Far greater transparency is required to allow stakeholders to understand the methodology that each carrier uses to calculate the three metrics and the underlying reason(s) for failure to satisfy a particular metric.
- Greater granularity is required to separately track the networks for MH and SUD services so that underlying deficiencies can be better targeted for corrective measures.
- Additional reporting is required to assess carrier compliance with the Parity Act for network adequacy.

The MA has posed questions regarding proposed revisions, and the following comments address those, as needed.

I. Definitions - § 31.10.44.02

A. Behavioral Health Care

The term **"behavioral health care"** creates confusion because it is used in the regulatory provisions to denote "mental health services" alone, even though the definition of "behavioral health care," under § 31.10.44.02, includes both mental health and substance use disorder services. For example, in the geographical distance chart, the catch-all facility listing, "other Behavioral Health/Substance Abuse Facilities," creates a redundancy for substance use disorder services and would be more accurately identified as "other Mental Health/Substance Abuse Facilities." Similarly, the wait time standard for urgent and non-urgent behavioral health/substance use disorder services would be more accurately designated "mental health/substance use disorder services." Likewise, the provider-patient ratio separately lists "behavioral health care or services" and "substance use disorder care or services," even though "behavioral health" as defined also includes substance use disorder services.

Recommendation: The term "behavioral health care" should be deleted and the terms "mental health care" and "substance use disorder care" should be separately listed and defined in § 31.10.44.02. Alternatively, the term "behavioral health care" should be defined as mental health services and a separate definition for "substance use disorder care" should be included. The term "mental health" should be substituted in place of "behavioral health" (or added to the term "behavioral health") in all provisions.

B. Waiting Time

We are concerned that the "waiting time" definition could be read to allow a carrier to calculate compliance by identifying a practitioner who is not qualified to treat the member's specific health condition. During the workgroup discussion of this metric, one carrier noted that identifying a provider with the required expertise to treat a MH or SUD condition can take longer than the designated wait time. In our view, the treatment of a MH or SUD condition is no different from the treatment of any other medical condition, insofar as all health conditions require specific expertise. The carrier's observation reflects the failure to develop a network of MH and SUD providers that have the range of expertise required to treat all conditions covered by the Diagnostic and Statistical Manual of Mental Disorders.

Recommendation: We recommend that the definition of "waiting time" be amended to clarify that the appointment must be with a practitioner or facility with the required expertise to treat the condition. We recommend that this definition be revised by adding "WITH A PROVIDER POSSESSING THE SKILL AND EXPERTISE TO TREAT THE CONDITION" after "appointment for services."

II. Filing Access Plans - § 31.10.44.03

We recommend that the access plan standards be revised to ensure the submission of more complete information, consistent with the statutory standard (Ins. § 15-112(c)), and greater transparency regarding the development of the carrier's network of mental health and substance use disorder providers.

A. Standardized Forms

To ensure the submission of complete and uniform information, the MIA should develop a standardized form(s) for both the access plan and the executive summary.

Recommendation: Among the required items, carriers should be required to identify:

- All elements included in Ins. § 15-112(c)(4). We note, for example, that the statute requires disclosure of the carrier's efforts to include local health departments in its network. § 15-112(c)(4)(vi). That information is not included in the executive summary form requirements. We believe each carrier should report whether it contracts with local health departments and identify the scopes of services, specifically identifying MH, SUD and/or medical services.
- All information required to be submitted in the waiver request provision, § 31.10.44.07, to the extent the carrier fails to meet any of the quantitative metrics (*See* discussion below at V).
- Information that the carrier deems to be proprietary or confidential and the rationale for requesting confidentiality. (*See* discussion below at VI). The Legal Action Center has filed PIA requests in both 2018 and 2019 seeking information related to the standards used to build the carrier's MH and SUD provider network in order to evaluate compliance with the Parity Act. That information should be disclosed pursuant to state and federal parity standards, under § 31.10.44.08(A), but has not been disclosed. The carriers should be required to justify any refusal to disclose parity-related information in their access plan, so that the MIA can expeditiously respond to PIA requests.

B. Uniform Methodology for Metric Calculations

We recommend that the MIA develop a methodology for each of the three metrics and a singular set of definitions to guide all necessary calculations. With uniform methodologies, the state will be better able to assess compliance and identify network gaps, and consumers will be able to compare networks across carriers. We recommend that the MIA set out both the methodologies and definitions in the regulations to ensure transparency.

C. Demonstration of Parity Act Compliance

The MIA, in the context of the Lt. Governor's Commission to Study Mental and Behavioral Health and in communications to the Finance and Health and Government Operations Committees regarding Parity Act compliance, has identified its network adequacy enforcement efforts as the vehicle for addressing gaps in access to MH and SUD services and carrier practices that may violate the Parity Act. The MIA cannot assess compliance with state and federal parity standards without obtaining a complete Parity Act compliance analysis for each carrier's network. Network adequacy is a non-quantitative treatment limitation under the Parity Act (45 C.F.R. § 146.136(c)(4)(ii)(D) and 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)), and each carrier should have conducted a parity compliance analysis of network adequacy to ensure that it is offering a plan that complies with the federal law. 45 C.F.R. § 146.136(h).

Recommendation: We recommend that the access plan require submission of the carrier's comparative analysis that demonstrates that the processes, strategies, evidentiary standards and other factors used to establish and implement the mental health and substance use disorder provider networks are comparable to and applied no more stringently than the processes, strategies, evidentiary standards and factors used to establish and implement the medical/surgical provider network, both as written and in operation. 45 C.F.R. § 146.136(c)(4)(i). The analysis of "in operation" compliance must include outcome measures data that will reveal any disparate outcomes that result from underlying discriminatory practices. Such data include, among other elements: (a) out-of-network utilization of mental health, substance use disorder, and medical/surgical services by Parity Act classification; (b) data on the number of MH, SUD, and medical/surgical providers that sought credentialing and number of credentialed providers in each provider network; (c) data on the time frame for processing credentialing applications for each provider type; and (d) data on reimbursement rate setting.

This type of outcome data for out-of-network utilization is required to be reported by other state departments of insurance in connection with network adequacy reports. *See, e.g.*, 10 CA ADC § 2240.5(d)(11) (requiring carriers to file network adequacy reports that provide data on out-of-network (OON) service utilization by members, including number of OON claims by type of provider, dollar value of total claims, average value per claim, total amount paid by health plan, average amount paid per claim and unpaid claim balances).

III. Travel Distance Standards - §31.10.44.04

The MIA has sought feedback on several issues related to the travel distance standards.

A. Appropriate List of Providers

The regulation tracks a number of MH and SUD providers, but it is missing critical providers of SUD and MH services. With the implementation of the ASAM criteria for all SUD medical necessity determinations, carriers will be required to have network providers that can deliver services at each level of care, including outpatient, intensive outpatient, partial hospitalization, residential treatment, inpatient services and withdrawal management (detoxification). In addition to the ASAM requirement, the state's SUD benefit mandate, Ins. § 15-802, requires coverage of these SUD services as well as opioid treatment services, which are delivered by Opioid Treatment Programs (OTPs) as well as other practitioners and programs.

We recommend that the regulations list additional SUD and MH providers so that the State can track the availability of providers for these mandated services and identify gaps that may be masked by these providers being included in the category of "other licensed providers" or "other Behavioral Health/Substance Abuse Facilities." *See, e.g.* 10 CA ADC § 2240.1(C)(6)(A) (setting out the full range of MH and SUD providers that are needed to establish an adequate network, including crisis intervention and stabilization, psychiatric inpatient hospital services, detoxification, outpatient MH and SUD evaluation and treatment psychological testing, OP services to monitor drug therapy, partial hospitalization, IOP, and short term treatment in crisis residential programs).

In addition, the dearth of child psychiatrists in Maryland prevents families from getting critically needed care for their children and adolescents. Tracking service availability of child psychiatrists and psychiatric nurse practitioners will likely document gaps and carrier efforts to address these treatment needs.

Recommendation: We recommend that the list of providers be expanded to include the following provider types and facilities: Licensed Counselor, Physician Certified in Addiction Medicine, Child Psychiatrist, Psychiatric Nurse Practitioner, Opioid Treatment Program, Outpatient Substance Use Disorder Facility, Substance Use Disorder residential treatment facility, and Outpatient Mental Health Clinic (OMHC).

The mileage metric for these practitioners should be the same as that required for LCSWs, psychologists and psychiatrists (10 miles, 25 miles and 60 miles for urban, suburban and rural areas, respectively). The mileage metric for facilities should be the same as that for Other Behavioral Health/Substance Use Disorder Facilities (10 miles, 25 miles and 60 miles).

B. Essential Community Providers

Essential community providers include community-based MH and SUD programs and local health departments, which currently meet the needs of many lower income and medically underserved individuals. As Marylanders transition between Medicaid and private insurance plans, it is important to have a range of MH and SUD providers included in provider networks to ensure continuity of care. We agree that the regulations should require a standardized methodology for calculating the 30% inclusion standard.

In selecting the methodology, we are concerned that the existing Maryland Health Benefit Exchange (MHBE) methodology falls short of ensuring coverage of a sufficient number of SUD and MH providers. Under the MHBE standards, community-based mental health and substance use disorder programs, local health departments and school-based health centers are included in a

single ECP expansion category, and carriers are only required to include a minimum of one (1) provider from each ECP category. In practice, this standard could result in a carrier demonstrating compliance even though no SUD or MH program has been included as an ECP.

To address the significant gaps in MH and SUD providers and the need for a range of SUD providers to provide all levels of care under the ASAM criteria, we recommend that the network adequacy regulations adopt a more expansive standard for calculating ECP compliance.

Recommendation: We recommend that carriers be required to include at least 30% of the available ECPs providing *medical services*, 30% of the available ECPs providing *SUD services* and 30% of the available ECPs providing *MH services* in each geographical region (urban, suburban and rural). The 30% calculation can be based on the formula set out in the MHBE April 3, 2019 Instructions on Meeting the Essential Community Provider Plan Certification Standard, available at https://www.marylandhbe.com/news-and-resources/toolbox/carriers-shop-administration/.

C. Additional Questions

In response to the MIA's other questions related to the geographic distance standards, we recommend:

- Carriers should be required to comply with the travel distance standards for 100% of enrollees.
- The mileage metrics should be based on "road travel distance."
- For student health plans, the travel distance should be measured from the student's place of residence, consistent with all other enrollees, rather than the school's address. As with employer plans, the enrollee's place of residence – not the workplace address – is the relevant point of access.

IV. Appointment Wait Time - § 31.10.44.05

We fully support the retention of the appointment wait time metric and the numerical standards, as they constitute the most important metric for assessing MH and SUD treatment availability. **We urge the MIA to evaluate and require carriers to disclose their efforts to meet this metric before revising any numerical standard. Without additional information, it is impossible to assess whether the carrier's network deficiencies are the result of carrier reimbursement or contracting practices, the availability of MH and SUD providers or other factors.** Moreover, if a carrier is not able to meet this metric because of the lack of SUD or MH providers, it may seek a waiver of the standard, under § 31.10.44.07.

A. Increased Granularity to Assess Availability of MH and SUD Providers

While we agree with the numerical standards for appointment wait time, we **recommend** that the "urgent care" standard be disaggregated for medical, behavioral health (mental health) and substance use disorder services and that carriers be required to report compliance with the 72-hour requirement separately for each condition. The combined standard likely masks differences in the satisfaction of the 72-hour requirement for MH, SUD and medical services. For the same reason, we also recommend that non-urgent behavioral health and substance use disorder services metric be reported separately for MH and SUD services.

B. Standard Methodology

We urge the MIA to develop a standardized methodology to measure wait time standards and clearly articulate the process and survey questions for data gathering, so that all carriers collect and report data in a uniform manner. In adopting the methodology, we **recommend** that the MIA adopt California's standard for reporting wait time and prohibit the use of the Consumer Assessment of Healthcare Providers & Systems (CAHPS) surveys, to the extent any carrier uses that survey instrument.

The California Department of Insurance requires carriers, as part of their quality assurance process, to conduct both an annual "covered person experience survey" and an annual "provider survey" using a "valid and reliable survey methodology" to ascertain compliance with the wait time metric. 10 CA ADC § 2240.15(c)(2)(B) and (C). The provider survey is also required to solicit provider perspectives and concerns regarding compliance with the standards. 10 CA ADC § 2240.15(c)(2)(C). The Department is required to make aggregate data from the consumer survey publicly available (§ 2240.15(c)(2)(B)) as well as the provider survey data. 10 CA ADC § 2240.15(c)(2)(C). We believe that both survey instruments are critical to assess compliance and that results from both should be made available to the public.

We also **recommend** that the MIA explicitly prohibit the use of CAHPS surveys for the purpose of assessing wait time compliance, as they do not contain questions that align with the State's metrics for appointment availability. There is no single CAHPS survey for MH and SUD services or settings, and the MH and SUD treatment questions included in other surveys relate to patient care experiences, not timeframes for accessing care on an urgent or non-urgent basis.

V. Waiver Standard - § 31.10.44.07

During the development of the network adequacy regulations, we expressed concern that carriers could use the waiver standard to avoid their obligation to establish robust networks. While we continue to have concerns that carriers are not taking necessary steps to improve their MH and SUD networks, a more troubling pattern has emerged in which most carriers do not seek a waiver of the standards notwithstanding non-compliance. The carriers' non-compliance coupled with their failure to request a waiver of standards results in the worst-case scenario: stakeholders have no information regarding the carrier's efforts to contract with MH and SUD and other providers. Stakeholders also have no way of determining whether the carrier addresses deficiencies in the MH and SUD network in a manner that complies with the Parity Act; i.e. is comparable to and no more stringently applied than its practices for addressing deficiencies in the medical provider network, as required under state and federal parity laws.

Recommendation: To remedy this lack of transparency, which prevents the development of evidence-based solutions, we urge the MIA to revise the waiver provision in the following ways.

- The MIA should require the submission of information required in the current waiver standard if the carrier that does not satisfy any quantitative metric. That information can be provided in the carrier's access plan but should also be made available to the public.
- In addition to the existing waiver information, the MIA should require carriers to submit the following information that will assist the MIA in determining whether carriers are complying with state and federal parity provisions in building networks and addressing gaps:

- A complete copy of the most commonly utilized network provider contract for each type of provider included in the provider network, including but not limited to hospital, individual physician, group physician, MH and SUD providers and facilities, outpatient medical facilities, residential treatment facilities and skilled nursing facilities. *See, e.g.*, 10 CA ADC § 2240.5(d)(3).
- A complete description of the actions the carrier takes to remedy network deficiencies for medical providers and MH and SUD providers and an explanation demonstrating that the carrier's actions comply with the Parity Act, both as written and in operation.

- The MIA should require each carrier to provide a copy of its waiver request to any provider named in the request. The MIA had proposed this requirement in 2017 in the draft network adequacy regulations, but removed the requirement in the proposed rule. We believe this notification requirement would provide a reasonable check on the carrier's representations and better enable providers to raise concerns about the carrier's contracting practices and efforts.

VI. Confidential Information in Access Plans - § 31.10.44.08

As noted above, the Legal Action Center has filed PIA requests in both 2018 and 2019 seeking information related to the standards carriers have used to build their carrier networks. That information, as well as other information relevant to a Parity Act analysis, should be disclosed pursuant to state and federal parity standards, as referenced in § 31.10.44.08. The MIA's failure to disclose this information suggests that a more explicit disclosure standard is needed. (The legal analysis supporting the Center's position, including references to federal guidance that explicitly removes information related to an NQTL analysis from protected proprietary and confidential information, has been submitted to the MIA in letters dated December 20, 2016 from Ellen Weber to Nancy Grodin and August 14, 2017 from Ellen Weber to Lisa Larson and will not be repeated here).

Recommendation: We recommend that the MIA revise the language in § 31.10.44.08(A) by removing "subject to § 15-802 of the Insurance Article" and inserting "EXCEPT AS REQUESTED TO ASSESS COMPLIANCE WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT."

Additionally, to the extent, the MIA adopts a uniform methodology for measuring compliance with all quantitative metrics, we believe that § 31.10.44.08(A)(1) and (2) should be removed from the provision, as the methodology for compliance testing would be made publicly available.

Finally, as noted above, we recommend that carriers be required to conduct consumer and provider surveys to evaluate appointment wait time. We recommend that each carrier's aggregate survey dats be made publicly available

VII. Executive Summary Form - § 31.10.44.09

In addition to the development of a standardized form for the Executive Summary, we recommend that the following item, required in the access plans standards, be included in the summary, under 31.10.44.09(A)(1):

- Total number and percentage of local health departments in the carrier's network with a designation of contracted services for MH, SUD and/or medical services.

Thank you for considering our recommendations. We will submit additional comments as needed.

Sincerely,

Ellen M. Weber, J.D.
Vice President for Health Initiatives

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