Network Adequacy Standards
Ensuring Access to Mental Health
and Substance Use Services in
Commercial Insurance

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Network Adequacy Standards
Background

• HB 1318 required MIA to issue regulations to establish quantitative criteria to evaluate network sufficiency by Dec. 31, 2017
• 9-month hearing process (June 2016 – Feb. 2017)
• Draft regulation issued April 7, 2017
• Comments accepted through May 8, 2017
• Formal notice and comment to follow
Recommendation Development
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

Research Findings

• 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
Research Findings

• 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

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

MIA Proposed Rule Overview

• Network Adequacy Quantitative Metrics
  • Appointment Wait Times
  • Geographic – Distance based on 4 population and/or population density areas
  • Physician/patient ratios
• Telemedicine – defined but no standards
• Access Plan Confidential Information
  • Methodology used to assess carrier performance
  • Methodology used to measure timely access to health services
  • Factors used to build carrier network
• Enforcement
  • Annual access plan submission with documentation of compliance with each network adequacy standard
Recommendations + Proposed Rule
Appointment Wait Time

<table>
<thead>
<tr>
<th>Services</th>
<th>Recommended Wait Time</th>
<th>Proposed Rule</th>
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<tbody>
<tr>
<td>All Urgent Care (medical, mental health and substance use)</td>
<td>24 hours</td>
<td>48 hours (PA required) 96 hours (PA not required)</td>
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<tr>
<td>Routine Primary Care</td>
<td>7 calendar days</td>
<td>15 calendar days</td>
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<tr>
<td>Preventive visit/well visit</td>
<td>30 calendar days</td>
<td>30 calendar days</td>
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<tr>
<td>Non-urgent specialty care</td>
<td>30 calendar days</td>
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<tr>
<td>Non-urgent ancillary care</td>
<td>30 calendar days</td>
<td>30 calendar days</td>
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<tr>
<td>Non-urgent mental health and substance use disorder care</td>
<td>7 calendar days</td>
<td>10 calendar days</td>
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</table>

Recommendations
Geographic Distance and Travel Time

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Large Metro Max Time (mins)</th>
<th>Large Metro Max Dist. (miles)</th>
<th>Metro Max Time (mins)</th>
<th>Metro Max Dist. (miles)</th>
<th>Micro Max Time (mins)</th>
<th>Micro Max Dist. (miles)</th>
<th>Rural Max Time (mins)</th>
<th>Rural Max Dist. (miles)</th>
<th>CEAC Max Time (mins)</th>
<th>CEAC Max Dist. (miles)</th>
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<td>10</td>
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<td>20</td>
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<td>Licensed Social Worker, Therapist, Counselor</td>
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<td>15</td>
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<td>Physician - Addiction Medicine</td>
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<td>35</td>
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<td>20</td>
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<td>70</td>
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<td>Outpatient MH/SUD clinic</td>
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**MIA Proposed Rule**  
**Geographic Distance Standards**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Large Metro Max Distance (miles)</th>
<th>Metro Area Max Distance (miles)</th>
<th>Micro Area Max Distance (miles)</th>
<th>Rural Area Max Distance (miles)</th>
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<tbody>
<tr>
<td>Provider Panel</td>
<td>HMO Staff Model</td>
<td>HMO Staff Model</td>
<td>HMO Staff Model</td>
<td>HMO Staff Model</td>
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<td>Primary Care Physician</td>
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<td>20</td>
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<td>Licensed Social Worker</td>
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<td>20</td>
</tr>
<tr>
<td>Psychiatry</td>
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<td>Psychology</td>
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<td>15</td>
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<td>10</td>
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<tr>
<td>Other Medical Provider not listed</td>
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<td>75</td>
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<td>Applied Behavioral Analysis</td>
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<tr>
<td>Inpatient Psychiatric Facility</td>
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<td>75</td>
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<tr>
<td>Other Facility not listed</td>
<td>15</td>
<td>15</td>
<td>40</td>
<td>90</td>
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**Essential Community Providers**  
**Recommendation and MIA Proposed Rule**

<table>
<thead>
<tr>
<th>Standard</th>
<th>Recommendation</th>
<th>Proposed</th>
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<tbody>
<tr>
<td>ECP Definition</td>
<td>QHP Standard – expand to include local health departments, school-based programs, outpatient mental health and community based substance use disorder treatment programs</td>
<td>Expanded to include local health departments, outpatient mental health and community based substance use disorder treatment programs</td>
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</tbody>
</table>
| ECP Contracting                 | QHP Standard  
* 30% of available ECPs in services area  
* offer contract to any willing local health dept., all Indian Health Care Providers, 1 ECP in each ECP category in each county | 30% of available ECPs in each of the defined rating areas |
| Separate ECP Contracting MH/SUD providers | 30% of mental health and substance use disorder providers | 30% of mental health and substance use disorder providers |
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
MIA Proposed Rule
Access Plan Standards

• Access Plan Confidential Information
  • Methodology used to assess carrier performance
  • Methodology used to measure timely access to health services
  • Factors used to build carrier network
• Consistent with Parity Act?