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

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

Recommendations Geographic Distance and Travel Time

	Large Metro		Metro		Micro		Rural		CEAC	
Specialty	Max Time (mins)	Max Dist. (miles	Max Time (mins)	Max Dist. (miles	Max Time (mins)	Max Dist. (miles	Max Time (mins)	Max Dist. (miles	Max Time (mins)	Max Dist. (miles
Primary Care	10	5	15	10	30	20	40	30	70	60
Alcohol/Drug Counselor	10	5	15	10	30	20	40	30	70	60
Licensed Social Worker, Therapist, Counselor	10	5	15	10	30	20	40	30	70	60
Physician - Addiction Medicine	20	10	30	20	50	35	75	60	95	85
Psychiatry	20	10	30	20	50	35	75	60	95	85
Psychology	20	10	30	20	50	35	75	60	95	85
Psychiatric Facility	30	15	70	45	100	75	90	75	155	140
Outpatient MH/SUD clinic	20	10	45	30	65	50	65	50	100	90

MIA Proposed Rule
Geographic Distance Standards

	Large Metro Max Distance (miles)		Metro Area Max Distance (miles)		Micro Area Max Distance (miles)		Rural Area Max Distance (miles)	
Specialty	Provider Panel	HMO Staff Model	Provider Panel	HMO Staff Model	Provider Panel	HMO Staff Model	Provider Panel	HMO Staff Model
Primary Care Physician	5	15	10	20	20	30	30	45
Licensed Social Worker	10	15	30	30	45	45	60	60
Psychiatry	10	15	25	30	45	46	60	60
Psychology	10	15	25	30	45	45	60	60
Other Medical Provider not listed	15	20	40	40	75	75	90	90
Applied Behavioral Analysis	15	--	30	--	60	--	60	--
Inpatient Psychiatric Facility	15	15	45	45	75	75	75	75
Other Facility not listed	15	15	40	40	90	90	120	120

Essential Community Providers
Recommendation and MIA Proposed Rule

Standard	Recommendation	Proposed
ECP Definition	QHP Standard – expand to include local health departments, school-based programs, outpatient mental health and community based substance use disorder treatment programs	Expanded to include local health departments, outpatient mental health and community-based substance use disorder treatment programs
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	

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?