LEGAL ACTION CENTER

ISSUE BRIEF

Maryland Adopts Enforceable Network Adequacy Standards for Private Health Plans

Quantitative Standards Require Insurance Carriers to Meet Specific Wait Time and Travel Standards for Providers of Substance Use Disorder and Mental Health Services

The Maryland Insurance Administration (MIA) has issued new regulations that establish quantitative standards to measure the composition of a carrier's provider network for health plans issued or renewed in Maryland after December 31, 2017. The new regulations apply to individual policies and small and large group commercial plans. Under the regulations, carriers must track and report compliance using three metrics - ***appointment wait time, geographical travel distance, and provider/enrollee ratios.*** The regulations set specific quantitative standards for substance use disorder and mental health providers, promoting greater inclusion of these providers in carrier networks and helping Marylanders access more affordable substance use disorder and mental health treatment.

As of August 2016,[1] twenty-three (23) states had adopted one or more quantitative standards for provider networks. **Maryland's quantitative standards are among the strongest in the nation.** Maryland is now:

- **One of six** states to require carriers to meet all three quantitative metrics – wait time, geographical distance, and provider/enrollee ratios.
- **One of six** states to adopt specific wait time standards for mental health and substance use disorder providers and **one of eleven** states with geographical standards for these providers.

I. Appointment Wait Time Standards

The wait time standard – the most important metric for individuals seeking health care - will require carriers to have a provider network with sufficient capacity to ensure plan members have access to substance use disorder and mental health services within 72 hours for urgent care and within 10 calendar days for non-urgent services.[2]

Waiting Time Standards	
Urgent Care (medical, behavioral health and substance use disorder services	72 hours
Non-urgent mental health/substance use disorder services	10 calendar days
Routine Primary Care	15 calendar days
Preventive visit/well visit	30 calendar days
Non-urgent specialty care	30 calendar days

The appointment wait times – measured from the time of the initial request for an appointment to the earliest date offered – for mental health and substance use disorder services are equal to or shorter than the wait times for other medical services.

Carriers are required to demonstrate that they meet these waiting time standards for 95% of enrollees that use that provider panel. Telehealth appointments may be used to satisfy the waiting time metric if clinically appropriate and the enrollee elects to use that service delivery arrangement.[3]

II. Travel Distance Standards

The travel distance standards require carriers to have a provider network that is sufficient to allow enrollees to access providers and facilities within a designated travel distance from their residence. [4] The regulations identify the most common types of providers and facilities, including a catch-all designation for providers and facilities not specifically identified, along with a travel distance for each provider/facility listing. The travel distance varies based on whether the enrollee resides in one of three geographical areas: urban, suburban or rural. The MIA has published a list of zip codes in each of the geographical areas, allowing consumers to identify the area in which they live and track the maximum travel distance to a designated health provider.

For mental health and substance use disorder services, the regulations impose travel distance standards for **four provider types – Applied Behavioral Analyst, Licensed Clinical Social Worker, Psychiatrist, and Psychologist**. All other mental health or substance use disorder providers with whom the carrier contracts, such as licensed professional counselors, fall into the catch-all category "All Other Licensed or Certified Providers." The regulations also identify **two facility types** for mental health and substance use disorder services: **Inpatient Psychiatric Facility and Other Behavioral Health/Substance Abuse Facilities.**

In general, the travel distance standards for mental health and substance use disorder providers **are comparable** to the distance standards for specialty medical providers. The travel distance standards for **mental health/substance use disorder *facilities* are shorter** than that for many facilities providing medical services – requiring community-based services to be in closer proximity to enrollees who need mental health or substance use treatment.

The maximum travel distances for these mental health and substance use disorders providers and facilities and several comparator medical care providers are:[5]

TRAVEL DISTANCE STANDARDS			
Provider Type	**Urban Area Maximum Distance (Miles)**	**Suburban Area Maximum Distance (Miles)**	**Rural Area Maximum Distance (Miles)**
Primary Care Physician, Gynecology, OB/GYN, Pediatrics – routine/primary care	5	10	30
Cardiovascular Disease	10	20	60
Applied Behavioral Analyst	15	30	60
Licensed Clinical Social Worker	10	25	60
Psychiatrist	10	25	60
Psychologist	10	25	60
All other licensed or certified provider under contract with a carrier (not listed)	15	40	90
Facilities			
Inpatient Hospitals	10	30	60
Skilled Nursing Facilities	10	30	60
Outpatient Dialysis	10	30	50
Inpatient Psychiatric Facility	15	45	75
Other Behavioral Health/Substance Abuse Facilities	10	25	60

In addition to the travel distance requirements, the regulations require that carriers include "essential community providers" – providers that serve predominantly low income or medically underserved individuals, including outpatient mental health and community-based substance use disorder programs – in their networks. Each provider panel that is not a group model HMO panel must have at least 30% of available essential community providers in each of the urban, rural and suburban zip code areas.[6]

III. Provider-to-Enrollee Ratio Standards

The final metric requires all plans, other than group model HMOs, to have one full-time provider to meet the following provider-to-enrollee ratios for the designated type of care:

PROVIDER : ENROLLEE STANDARDS	
Type of Care	**Provider to Enrollee Ratio**
Primary Care	1:1200 enrollees
Pediatric Care	1:2000 enrollees
Obstetrical/Gynecological Care	1:2000 enrollees
Behavioral Health Care and Services	1:2000 enrollees
Substance Use Disorder Care and Services	1:2000 enrollees

IV. Carrier Request for Waiver of Requirements

A carrier may request a waiver of the network requirements for up to 1 year if it can demonstrate to the MIA that the providers needed to establish an adequate network:

- are not available to contract with the carrier;
- are not available in sufficient numbers;
- have refused to contract with the carrier; or
- are unable to reach agreement with the carrier. [7]

In seeking a waiver, the carrier must describe any previous waivers granted by the MIA and submit detailed information about the providers the carriers attempted to contract with and their reasons for not contracting. The regulations do not limit the number of waivers a carrier may receive, but require the carrier to identify steps it will take to avoid future waiver requests.[8]

V. Network Sufficiency Results: Carrier Reporting and Transparency Requirements

Carriers are required to file an annual Network Access Plan that demonstrates that each of its provider panels meets the network sufficiency standards and a Network Adequacy Access Plan Executive Summary Form that summarizes its results in satisfying the three quantitative metrics.[9] The Executive Summary Form must identify:

- the percentage of enrollees for which the carrier met the travel distance standard for each of the provider/facility types listed
- the percentage of enrollees for which the carrier met the wait time standards, including the total percentage of telehealth appointments counted for the wait time results
- whether the percentage of provider-to-enrollee ratios met the regulatory standards.[10]

Carriers are required to file their initial access plan(s) and summary form(s) no later than July 1, 2018 and annually by July 1 of each year.[11]

The public may obtain a copy of the carrier's summary form[12] and non-confidential portions of its access plan.[13] Specific portions of the access plan are deemed confidential, **but any carrier information related to the development and implementation of its provider network that is necessary to assess compliance with the Mental Health Parity and Addiction Equity Act (Parity Act) must be made available to the public upon request.** [14]

VI. Quantitative Network Adequacy Standards: An Important Tool to Improve Access to Mental Health and Substance Use Disorder Treatment

Maryland's citizens face significant barriers in accessing substance use disorder and mental health treatment under their commercial health insurance plans. Over the past three years,[15] the MIA has documented that the state's carriers do not have adequate provider networks to meet the needs of their enrollees with these life-threatening health conditions. The MIA's second market conduct survey, completed in mid-2017, found, for example, that, for some carriers, in-network opioid treatment facilities (OTPs) do not exist in six (6) Maryland counties and that inpatient hospital, inpatient non-hospital facilities or intensive outpatient

treatment programs for opioid use disorders do not exist in three (3) counties.[16] Significant gaps were also identified 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.[17]

The MIA's identification of network provider gaps is consistent with the 2017 Milliman Research Report that compared out-of-network utilization and reimbursement rates for behavioral health and medical/surgical services in commercial PPO and other non-commercial health plans, using claims data for 2013-2015.[18] The report found disproportionate rates of out-of-network utilization of behavioral health services compared with medical/surgical services for inpatient and outpatient facility services and outpatient office visits in many states.

Based on Milliman's analysis of 2015 claims for Maryland enrollees, the proportion of out-of-network **inpatient services** utilized for behavioral health services was **7 times higher** than for out-of-network inpatient medical/surgical services (3 points higher than the national average); **3.5 times higher for outpatient facility** behavioral health services than outpatient medical/ surgical facility services; and **9 times higher for outpatient behavioral health office visits** than for primary or specialty care office visits (4 points higher than the national average).[19] **Maryland ranked as the 3rd worst state in the utilization of out-of-network providers for behavioral health office visits.**[20] Consumers shouldered significantly higher out-of-pocket costs for their mental health and substance use care because they were forced to use out-of-network services.

The reimbursement data revealed that, in Maryland for 2015, **primary care and specialty providers were paid 27.6% and 20% higher, respectively, than behavioral health providers** for office visits that were billed **under identical or similar codes.** The lower reimbursement rate for mental health and substance use disorder providers likely contributes to the significant gaps in network providers.

These gaps in provider networks and reimbursement rates for substance use disorder and mental health services raise a **red flag** for potential violations of the Mental Health Parity and Addiction Equity Act. Federal and state law requires carriers to adopt and implement non-discriminatory standards for the inclusion of mental health and substance use disorder providers in their networks and the setting of reimbursement rates. Maryland's new network adequacy standards will provide data to uncover disparate practices that limit access to care and track whether carriers are complying with the Parity Act.

With close monitoring of carrier waiver requests, provider experience in contracting with carriers, and utilization of out-of-network services, regulators, consumers, and health care providers will be able to identify:

- Network gaps that can be addressed by linking interested providers with carriers.
- Carrier contractual practices that create barriers to provider participation in networks, including more restrictive contract requirements, lower provider reimbursement rates and more burdensome utilization management requirements.
- Additional consumer protections that are needed to mitigate high out-of-pocket costs for patients who must use an out-of-network provider because of on-going gaps in carrier networks.

Please contact Ellen Weber (eweber@lac.org) with questions or requests for information.

This Brief was created as part of the Parity@10 Campaign, a three-year initiative to establish effective models for robust enforcement of the Parity Act in 10 states and to disseminate those models across the country. The campaign's goal is to ensure that insurance carriers and State Medicaid programs offer fully parity compliant substance use and mental health benefits and put an end to a complaint-driven enforcement model that forces consumers to fight for the evidence-based health care they need and are entitled to receive.

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[1] Drug Policy and Public Health Strategies Clinic, "Fifty-State Survey - Network Adequacy Quantitative Standards: Geographic Criteria, Appointment Wait Times & Provider/Enrollee Ratios (Oct. 18, 2016), available at http://insurance.maryland.gov/Consumer/Documents/agencyhearings/UMD-LawSchool-DrugPolicyClinic-NetAdqSurvey10182016.pdf

[2] COMAR §31.10.44.05.C.

[3] COMAR §31.10.44.05.A(2).

[4] The regulations establish different distance standards for Group Model Health Maintenance Organizations, which are generally greater than the travel distance standards for other carrier networks and track the travel distance from either the enrollee's residence or place of employment. A group model HMO is defined as a health maintenance organization that "(a) contracts with one multispecialty group of physicians who are employed by and shareholders of the multispecialty group; and (b) provides or arranges for the provision of physician and other health care services to patients at medical facilities operated by the HMO or employs its own physicians and other providers on a salaried basis in health maintenance organization buildings to provide care to enrollees of the health maintenance organization." COMAR § 31.10.44.02.B(7).

[5] COMAR §31.10.44.04.A(5).

[6] COMAR §31.10.44.04.C(1).

[7] COMAR §31.10.44.07.A and B.

[8] COMAR §31.10.44.07.C.

[9] COMAR §31.10.44.03.

[10] COMAR §31.10.44.09.

[11] COMAR §31.10.44.03.A.

[12] COMAR §31.10.44.09.B.

[13] COMAR §31.10.44.08.

[14] COMAR §31.10.44.08.A and Attorney General's Certification, 44 MD REG 1171, 1182 (Dec. 8, 2017).

[15] The MIA has conducted two market conduct surveys from 2014 to 2017 that assessed carrier provider networks for mental health and substance use disorder providers. The results are set out in the MIA's reports to the Finance Committee of the Maryland General Assembly. Letters from Al Redmer, Commissioner, to Senator Thomas McLain Middleton (June 29, 2016 and June 30, 2017). The 2017 letter does not contain provider network information for two of the State's largest carriers, UnitedHealthcare and CareFirst.

[16] For one or more of three carriers (Aetna, Cigna and Kaiser Permanente), 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 Worchester Counties. Redmer 2017 Letter at 4 n. 2 and 3.

[17] For one or more of three carriers (Aetna, Cigna and Kaiser Permanente, 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, Worchester and Talbot Counties, and in-network in-patient or residential services do not exist in Charles, Garrett, Kent, Queen Anne's, Somerset, Talbot and Worchester Counties. Redmer 2017 Letter at 4 n. 2 and 3.

[18] Stephen P. Melek, Daniel Perlman and Stoddard Davenport, "Addiction and Mental Health vs. Physical Health: Analyzing Disparities in Network Use and Provider Reimbursement Rates." Dec. 2017. *Available at* http://www.milliman.com/uploadedFiles/insight/2017/NQTLDisparityAnalysis.pdf.

[19] Melek, et al. at App. C, F, and I.

[20] Melek, et al. at Supp. Table 3.