AMERICAN PSYCHIATRIC ASSOCIATION

800 Maine Avenue, S.W.
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Washington, D.C. 20024

January 13, 2020

Al Redmer, Jr., Commissioner
Maryland Insurance Administration
200 St. Paul Place
Baltimore, MD

Dear Commissioner Redmer:

The American Psychiatric Association, the national medical specialty society representing over 37,800 psychiatric physicians and their patients, and the Maryland Psychiatric Society, which represents over 700 psychiatrists, would like to respond to the Maryland Insurance Administration's (MIA) soliciting feedback regarding its current network adequacy standards and filing process. Our comments will focus on network adequacy standards as they relate to a plan's compliance with the Mental Health and Addiction Equity Act of 2008 (MHPAEA).

It is essential to note that evaluation of a plan's compliance with federal/state statutes and regulations regarding health plan network adequacy, such as Maryland's network adequacy standards, is a separate inquiry from whether a plan's network is in compliance with MHPAEA. As discussed more fully below, network adequacy or a beneficiary's ability to access in network services for a mental health or substance use disorder (MH/SUD) is a non-quantitative treatment limitation (NQTL) under MHPAEA and as such, must satisfy the regulatory test for same. Stated another way, even if a plan satisfies the network adequacy standards that MIA eventually adopts, the plan must also satisfy MHPAEA and demonstrate it has done the comparative analysis mandated by the NQTL test. A plan's failure to comply with the mandated NQTL tests, could result in a plan providing its patients with a network that satisfies Maryland's network adequacy standards but fails to provide patients with MH/SUD conditions access to care that is on par with access to medical/surgical services under the plan. A recent study completed by Milliman illustrates this problem and identifies Maryland as one of the worst performing states in the country when it comes to patient access to in network MH/SUD care.[1]

We think that MIA's approval of a plan's provider network must assure compliance with all applicable law and therefore recommend that plans be required to demonstrate compliance with MHPAEA's NQTL requirements in addition to the other standards established by MIA.

Network Adequacy is a NQTL

Network adequacy is a NQTL under MHPAEA, and as such is subject to the parity analysis to determine whether a health plan complies with the regulatory tests at 45 C.F.R. 146.136(c)(4)(i). An NQTL is a plan limitation which is not numerical in nature

[1] http://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf

but otherwise limits the scope or duration of a health plan's benefits. A plan participant's inability to appropriately access in-network treatment is, de facto, a limitation on the scope of the plan's benefits. Therefore, to be compliant with MHPAEA, plans must analyze their networks and apply the NQTL tests which involves comparing the performance of the MH/SUD network to the medical/surgical network.

MIA's network adequacy standards themselves do not involve this comparative analysis. However, these standards do provide a helpful starting place for the NQTL analysis. A plan's compliance with state regulatory network adequacy standards can satisfy the "as written" component of the NQTL test; the MH/SUD and medical surgical networks are comparable on their face because they were developed and established by the same required standards and therefore were "no more stringently" applied to the MH/SUD benefits.[2]

The next part of the NQTL analysis, the "in operation" inquiry is the more critical question, and again, is separate and apart from a plan's ability to satisfy a state's network adequacy requirements. The "in operation" analysis looks at how the MH/SUD and medical/surgical networks perform as compared to one another.

<u>A Plan's Provider Network Can Satisfy State Regulatory Network Adequacy Standards and Fail the NQTL test.</u>

Whether a plan's provider network fails the "in operation" portion of the comparative analysis can be indicated by:

- The ability of plan beneficiaries to access an in-network MH/SUD provider in a timely manner as compared to timely access to an in network medical/surgical provider.
- How frequently plan beneficiaries access out of network (OON) care for MH/SUD care as compared to medical/surgical care.
- The ability of plan beneficiaries to access MH/SUD benefits at all, because an in network provider is not available and the plan does not offer OON benefits; or the plan offers OON benefits but the patient does not use them because they cannot afford to pay the difference between what the plan will pay and what they are charged.

In these situations, the scope of covered MH/SUD benefits is limited, per the NQTL definition, and potentially noncompliant with MHPAEA when:

- Beneficiaries' wait times to access in network MH/SUD services regardless of the type (e.g., office visit or hospital admissions) are not similar to those of beneficiaries seeking care for a medical/surgical condition.
- Beneficiaries must secure treatment from an OON provider at a higher cost, either from higher cost sharing (if the plan has an OON benefit) or paying the total cost (if there is no OON benefit).

When beneficiaries have no OON benefit and in network care is not available and the beneficiary cannot afford to pay full fees for services, the patient does not receive care at all. If care is available on the

[2] A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification. 29 CFR 2590.712(c)(4)

medical/surgical side, the patient does not have parity in health care benefits. MHPAEA compliance also involves the plan's efforts to ensure a robust network to its beneficiaries. The plan's efforts to attract and retain providers, are influenced by various factors, such as, how well the plan reimburses providers, the plan's requirements for credentialing, the obligations imposed by the plan's contract (for example, the provider's conformity to burdensome medical management protocols) and are subject to the NQTL comparable analysis. Simply put, plans need to analyze how they are attracting and retaining providers for MH/SUD benefits as compared to medical/surgical benefits and ensure that they satisfy the NQTL tests. Again, this analysis is separate from a plan's compliance with network adequacy standards.

There is abundant evidence that the networks available to beneficiaries in the state of Maryland are not complying with MHPAEA. MIA has conducted market conduct surveys that assessed carrier provider networks for MH/SUD providers. The results suggest that carriers have not assessed "in operation" compliance and are unable to produce any written reports documenting the results of their compliance reviews.[3] Additionally, carriers did not submit all data that is required by the MIA network adequacy standards and none of them satisfied all three metrics.[4]

Further, Milliman's recently updated analysis of network adequacy shows Maryland outpatient access is the fourth worst in the nation. Maryland's out of network inpatient use for behavioral care as compared to medical/surgical care rose from 5.5 to 9.3 times more likely —nearly twice the national average. Maryland's out of network outpatient facility use for behavioral care as compared to medical/surgical care rose from 2 to 3.6 times more likely. Maryland behavioral health providers received 18% less than other doctors for similar billing codes. These gaps in provider networks and reimbursement rates for MH/SUD care raise a red flag for potential violations of MHPAEA.

MHPAEA demands that plans assess whether their provider network is in fact functioning properly – the "in operation" dimension of the NQTL test. Plans can utilize numerous, readily available measures to properly evaluate the comparative adequacy of their networks. Gross disparities between the performance of the MH/SUD and medical/surgical networks suggest a parity compliance problem.

Network Adequacy Standards

Network adequacy is the ability of a plan to provide beneficiaries with access to a reasonable number of providers within a reasonable amount of time and distance. "Reasonableness" can be defined and measured in a multitude of different ways, including waiting times for an appointment, travel distance to the office, and provider to population ratio, for example. Many states, including Maryland, require plans to satisfy certain standards as a prerequisite to selling a plan's coverage to their residents. Maryland's regulations, adopted in 2017, require carriers to track and report compliance using three metrics - appointment wait time, geographical travel distance, and provider/enrollee ratios.[5]

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[3] https://insurance.maryland.gov/Consumer/Pages/MHPAEA-Enforcement-Actions.aspx

[4] https://insurance.maryland.gov/Consumer/Pages/Network-Adequacy-Regulations-Information.aspx

[5] https://insurance.maryland.gov/Documents/newscenter/legislativeinformation/31.10.44-NetworkAdequacy-FinalPublished1282017.pdf

We commend MIA's efforts to create and impose these standards on plans. However, as Maryland Psychiatric Society noted in its August 21, 2017 comments[6] on the proposed regulations, **these standards alone will not protect Maryland citizens from the discrimination outlawed by MHPAEA.** Further, there is not a standardized methodology for calculating the three metrics and we encourage MIA to develop and adopt that methodology.

We ask that as the MIA goes forward with adopting network adequacy standards, it remain committed to holding plans accountable for their legally mandated responsibility to conduct the NQTL analysis of the plans they sell in Maryland. We continue to recommend that MIA include incentives to ensure that carriers make every effort to establish provider networks that are adequate for enrollees *in practice.* To that end, **we recommend** adding to the list of required items for the Executive Summary Form:

> *A calculation by Provider Type of the ratio of out of network claims to total claims for each CPT code processed for that Provider Type during the preceding year.* (Per MHPAEA, the out of network ratios for MH/SUD providers should be comparable to those of medical/surgical providers. Some patients pay out of pocket and never file an out of network claim, so it could be argued that the out of network MH/SUD ratio should actually be lower.)

Thank you for your consideration. We appreciate this opportunity to give feedback on the network adequacy regulations. We would be glad to provide any additional information you may need. Please contact Maureen Maguire, JD at mbailey@psych.org or 202-559-3730 or Heidi Bunes at heidi@mdpsych.org or 410-625-0232 if you have questions.

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[6] https://insurance.maryland.gov/Consumer/Documents/agencyhearings/MDPsychiatricSociety-NetworkAdequacy-Comments-82117.pdf