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EQUAL INSURANCE COVERAGE OF SUBSTANCE USE AND MENTAL HEALTH DISORDERS

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Building Better Networks and Improving Access to Substance Use Disorder and Mental Health Providers:

Lessons from Maryland

Maryland Strengthens Network Adequacy Standards for Private Health Plans

The Maryland Insurance Administration (MIA) has issued updated regulations governing network adequacy standards for state-regulated commercial insurance plans. Following a 3-year review process, during which telehealth became a significant modality of care delivery, the MIA has strengthened standards and oversight to improve substance use disorder (SUD) and mental health (MH) provider availability and accessibility. The final rule has retained key quantitative metrics to regulate and measure network sufficiency – travel distance, appointment wait time, inclusion of essential community providers, and provider-patient ratios – all of which impose quantitative standards for MH and SUD services that are comparable to or more protective than standards for medical/surgical services, as required under the Mental Health Parity and Addiction Equity Act (Parity Act).

The updated network adequacy standards will:

- Improve coverage of SUD and MH providers in private health plan networks by requiring carriers to:
  - track network inclusion of additional types of SUD providers and facilities
  - report data separately for SUD and MH providers
  - use uniform methodologies for tracking carrier network adequacy compliance;
- Ensure access to in-person services based on the consumer's choice for service delivery while allowing carriers to claim a telehealth credit to satisfy travel distance and appointment wait time metrics based on evidence of clinical appropriateness and telehealth availability and accessibility;
- Require carriers to report median appointment wait times semi-annually to plan members and promptly report deficiencies in meeting wait time requirements and corrective action plans to the MIA; and
- Require carriers to submit significantly more detailed information to the MIA in their annual access plan and, beginning in July 2024, to submit quantitative data on critical access issues, including out-of-network utilization of SUD, MH and medical services, approval of requests for non-network services, and network-related complaints.

Maryland's updated network adequacy standards impose stronger standards than federal requirements for qualified health plans. New data reporting requirements offer an opportunity to assess gaps in the availability of MH and SUD providers in comparison to providers of other medical services and identify possible violations of the Parity Act. These standards will advance efforts to improve oversight of and accountability for carrier coverage of SUD and MH care and compliance with the Parity Act in commercial health plans. **Increasing transparency of the data submitted to the MIA will ensure that consumers have access to information they need to exercise their right to insurance-based care and policymakers can continue to improve standards for network coverage. Other states and policymakers can use Maryland's standards as a model to ensure more equitable access to SUD and MH care.**

Network Adequacy Standards

Carriers are required to develop and maintain a provider network that ensures enrollees have access to participating providers who can deliver the full scope of benefits and services in the health plan. The network must include providers who deliver accessible services to individuals with disabilities; culturally appropriate services based on language proficiency, diverse cultural, racial and ethnic backgrounds; and services for individuals of all genders, sexual orientation and gender identities. To monitor sufficiency, carriers are required to:

- Continuously monitor their networks and conduct, at a minimum, a quarterly internal audit of appointment wait time, travel distance and provider-patient ratio satisfaction; and
- Continuously verify and update their network directories.

COMAR § 31.10.44.03.

Appointment Wait Time Standards

The wait time standard – the most important metric for determining whether care is available - will require carriers to have a provider network with sufficient capacity to ensure plan members have access to SUD and MH within 72 hours for urgent inpatient and outpatient care and within 10 calendar days for non-urgent services. To improve tracking of services, the regulations require carriers to report metrics for medical, SUD and MH services separately. ***The appointment wait times – measured from the time of initial request for an appointment to the earliest date available for an in-person visit – for MH and SUD services are equal to or shorter than those for other medical services.***

Health Care Appointment Waiting Time Standards

	Medical/Surgical Care	SUD Care	MH Care
Urgent care	72 hours	72 hours (inpatient)	72 hours (inpatient)
		72 hours (outpatient)	72 hours (outpatient)
Non-urgent care	15 calendar days (routine primary care) 30 calendar days (preventive & specialty care)	10 calendar days	10 calendar days

COMAR § 31.10.44.06.E. Carriers are required to determine whether they meet the above metrics on a semi-annual basis, using a **new standardized methodology**[1] designated in the regulations. They must:

- inform enrollees of the median time for obtaining an appointment for each service; and
- notify the MIA within 10 business days if they do not meet each metric for 90 percent of appointments in any category and identify the efforts that will be taken to correct deficiencies.

With MIA approval, carriers may apply up to a 10 percentage point credit for telehealth services that are clinically appropriate, available and accessible if a metric is not met based on in-person services. COMAR § 31.10.44.08.C. *See* Description of Telehealth Credit Standards below.

[1] Carriers must conduct a direct contact survey of a designated number of participating providers selected randomly and request the next available appointment. Alternatively, the MIA may conduct a centralized direct contact survey of the carrier's participating providers, selected randomly, to measure appointment availability for each appointment type..

Travel Distance and Essential Community Provider 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. [2] The travel distance varies based on whether the enrollee resides in one of three geographical areas: urban, suburban or rural.[3] The regulations establish a uniform methodology for measuring, mapping and calculating the travel distance metrics and require detailed reporting, by zip code and geographical area, of the number and percentage of enrollees for whom that metric is met and not met in the carrier's access plan. COMAR § 31.10.44.05.A. The carrier's network must satisfy the travel distance for 100 percent of its enrollees.

The regulations expand the types of SUD and MH providers and facilities that must be tracked including:

- Addiction Medicine
- Applied Behavioral Analyst
- Licensed Clinical Social Worker
- Licensed Professional Counselor
- Psychiatry
- Psychiatry-Geriatric
- Psychiatry – Adolescent and Child Outpatient
- Psychology

All other mental health or substance use disorder providers with whom the carrier contracts fall into the catch-all category "All Other Licensed or Certified Providers." The regulations also expand the types of facilities that must be tracked for MH and SUD including:

- Inpatient Psychiatric Facility
- Opioid Treatment Services Provider
- Outpatient Mental Health Clinic
- Outpatient Substance Use Disorder Facility
- Residential Crisis Services
- Substance Use Disorder Residential Treatment Facility

Enrollees must have access to most SUD and MH providers within 10 miles of their residence in an urban area, 25 miles in a suburban area and 60 miles in a rural area for non-group HMO plans. For facility-based services, they must have access within 10-15 miles in an urban area, 20-45 miles in a suburban area, and 60-75 miles in a rural area, based on the facility type. In general, the travel distance standards for MH and SUD providers **are comparable** to the distance standards for specialty medical providers. The travel distance standards for ***MH and SUD facilities are shorter*** than many facilities providing medical services – requiring a sufficient number of community-based services so that they are in closer proximity to enrollees who need such treatment.

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[2] 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, at the carrier's option, 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(9).

[3] 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, based on the regulatory standards, track the maximum travel distance to a designated health provider.

The following chart sets out the maximum travel distances for these MH and SUD providers and facilities and several comparator medical care providers (newly listed providers and facilities italicized and marked with an asterisk in chart):

Maximum Travel Distances to Health Care Providers Based on Patient Location

	Urban Area	Suburban Area	Rural Area
***Addiction Medicine**	*10 mi*	*25 mi*	*60 mi*
Primary Care Physician, OB/GYN, Pediatrics – routine/primary care	5 mi	10 mi	30 mi
Cardiovascular Care	10 mi	20 mi	60 mi
Applied Behavioral Analyst	15 mi	30 mi	60 mi
Licensed Clinical Social Worker	10 mi	25 mi	60 mi
***Licensed Professional Counselor**	*10 mi*	*25 mi*	*60 mi*
Psychiatry - Outpatient	10 mi	25 mi	60 mi
***Psychiatry – Adolescent & Child, Outpatient**	*10 mi*	*25 mi*	*60 mi*
***Psychiatry – Geriatric, Outpatient**	*10 mi*	*25 mi*	*60 mi*
Psychology	10 mi	25 mi	60 mi
All other licensed or certified providers under contract with a carrier (not listed)	15 mi	40 mi	90 mi
FACILITIES			
Inpatient Hospitals – Acute	10 mi	30 mi	60 mi
Inpatient Psychiatric Facility	15 mi	45 mi	75 mi
***Opioid Treatment Services Provider**	*15 mi*	*25 mi*	*60 mi*
Outpatient Dialysis	10 mi	30 mi	50 mi
***Outpatient MH Clinic**	*15 mi*	*30 mi*	*60 mi*
***Outpatient SUD Facility**	*15 mi*	*30 mi*	*60 mi*
***Residential Crisis Services**	*10 mi*	*30 mi*	*60 mi*
Skilled Nursing Facility	10 mi	30 mi	60 mi
***SUD Residential Facility**	*10 mi*	*25 mi*	*60 mi*

COMAR § 31.10.44.05.A(5). With MIA approval, a carrier may receive a telehealth credit for no more than 10 percent of enrollees for telehealth services that are clinically appropriate, available and accessible for each provider/facility type in a geographic area in which the metric is not met. COMAR § 31.10.44.08.B. *See* Description of Telehealth Credit Standards below.

In addition to the travel distance requirements, each carrier must have the ability to identify, by county, the number of participating providers by facility and for each specialty code (COMAR § 31.10.44.03.A(7)) and must report this information in their access plans to the MIA, upon request.

Finally, the regulations strengthen the requirement that carriers include "essential community providers" – providers that serve predominantly low income or medically underserved individuals – in their networks. Carriers (other than group model HMOs) **must now separately include at least 30% of available SUD ECPs, MH ECPs and medical service ECPs** in each of the urban, rural and suburban zip code areas. COMAR § 31.10.44.05.C(1).

Provider-to-Enrollee Ratio Standards

The final metric requires all plans, other than group model HMOs, to have 1 full-time provider of SUD services and 1 full-time provider of MH services for every 2000 enrollees to meet the provider-to-enrollee ratios. COMAR § 31.10.44.07.

Telehealth Credit and Consumer Choice of Service Delivery

The regulations establish a new telehealth credit for both appointment wait time and travel distance that can be applied to satisfy the standard for a service category or provider/facility type that are not met with an in-person appointment and/or at a "brick and mortar" location. Essentially, if a carrier offers telehealth services, they can request that those services be credited to meet the required metric. For each credit, the carrier must submit supporting documentation to demonstrate that telehealth services are clinically appropriate, available and accessible in order to obtain the MIA's approval to apply the credit. **Enrollees who do not wish to use telehealth services are entitled to receive in-person services, and carriers are required to demonstrate adherence to that standard through documentation of plan standards and data supporting on-the-ground enrollee experience.**[4] COMAR § 31.10.44.08.C.

Travel Distance Credit

The travel distance credit is a mileage credit that increases the allowable travel distance by 5 miles for an urban geographic area, 10 miles for a suburban area and 15 miles for a rural area. In other words, the respective travel distance is extended to capture more plan enrollees who fall outside the established travel distance, if telehealth is offered. A carrier may request that the credit be applied to a maximum of 10 percent of enrollees for each provider/facility type in each of the geographic areas. In seeking a credit, the carrier must identify the percentage of enrollees for which the carrier met the travel distance metric before and after the mileage credit was applied. COMAR § 31.10.44.08.B. The MIA is expected to provide examples of how the credit will be operationalized.

Appointment Wait Time Credit

A carrier may request an appointment wait time credit of up to 10 percentage points for any service type in which it does not meet the designated appointment time for 90 percent of enrollees. To protect consumer choice for an in-person appointment, the carrier must demonstrate that it:

[4] The telehealth credit is modeled after a federal Medicare Advantage standard that provides a telehealth credit for travel distance/travel time requirements. 42 C.F.R. § 422.116(d)(5). Like the Medicare Advantage standard, Maryland's standards protect an enrollee's right to in-person care and requires notification and documentation of such right. The MIA has imposed more stringent standards than federal Medicare Advantage to qualify for the telehealth credit.

- provides coverage for corresponding in-person services for enrollees who choose not to use a telehealth service; and
- maintains and adheres to written policies to assist enrollees for whom telehealth is not clinically appropriate, available or accessible to obtain in-person services within a reasonable distance with a participating provider or a non-participating provider at no greater cost than if the service were obtained from a participating provider.

The carrier must report the percentage of appointments that met the metric in each service type before and after application of the credit. COMAR §31.10.44.08.C. The MIA is expected to provide examples of how the credit will be operationalized.

Required Documentation for Approval

To support its request for any credit, a carrier must submit substantial data to establish that telehealth services are clinically appropriate, available and accessible. Generally, the carrier must submit documentation on:

- any requirements or incentives provided for participating providers to offer telehealth services;
- a description of the telehealth services including modalities covered, types of platforms, telehealth-only vendors and services provided as telehealth-only;[5] and
- telehealth services that are available 24/7 and the availability of telehealth kiosks in convenient locations.

Evidence that telehealth is clinically appropriate and available for services by each provider type and appointment type include:

- telehealth utilization data for a specific provider or appointment type;
- survey results or attestations that telehealth is offered by the specific provider or appointment type; and
- enrollee survey results demonstrating a willingness and ability to use telehealth for the specific provider or appointment type.

Additional information is required to support a request for the mileage credit, demonstrating that telehealth services are available and accessible in the zip codes in which the credit is being applied. This includes utilization data comparing telehealth to in-person claims in the specific zip code and on a statewide basis.

For the appointment wait time credit, the carrier is required to provide plan documents that describe the availability of in-person and telehealth services, education materials informing enrollees of available carrier assistance to get a timely appointment, and evidence that enrollees are, in practice, able to get timely in-person services. COMAR § 31.10.44.08.D.

Network Sufficiency Results: Transparency Requirements

Carriers must file an annual Network Adequacy Access Plan Executive Summary Form, using a standardized format, that summarizes its results in satisfying the quantitative metrics. COMAR § 31.10.44.11. The Executive Summary Form must identify:

- the percentage of enrollees for which the carrier met the travel distance standard in each geographical area for each of the provider/facility types listed, and, if a telehealth mileage credit

[5] Under Maryland's insurance law, a carrier is prohibited from offering telehealth-only services for MH and SUD services. INS. § 15-139(c)(1)(iii).

was applied, identify (with an asterisk) the provider types and geographic areas to which the credit was applied;[6]
- the total number of SUD ECPs, MH ECPs and medical ECPs in the carrier's network in each geographical area and percentage of ECPs by type and geographical area that are participating in the network;
- the total number and percentage of local health departments in the carrier's network that are providing SUD, MH, and medical services;
- the median wait time to obtain an in-person appointment with a participating provider in each of the designated categories, and, if a telehealth credit was applied when determining if the carrier satisfied the wait time metric, the carrier may include a statement disclosing the availability of telehealth appointments to supplement in-person appointments for the specific category; and
- for the provider-to-enrollee ratios, the number of providers in the panel for each category of providers.

The public is entitled to obtain a copy of the carrier's summary form, which is posted on the MIA's website. COMAR § 31.10.44.11.B.

Network Access Plans

Carriers are required to file an annual Network Access Plan that demonstrates that its provider panel(s) meets the network sufficiency standards. The regulations significantly expand information carriers must submit to document their efforts to build networks of providers who are culturally competent and racially, ethnically, and linguistically diverse to meet the demographic profile of plan enrollees. COMAR § 31.10.44.04.E and F. Beginning with the 2024 access plan, carriers must submit detailed quantitative data that will reveal the breadth and depth of the carrier's network, including:

- out-of-network utilization, including claims received and paid, claims for services in geographic areas in which the carrier did not meet required travel distance metrics, and the ten provider types with the highest number and percentage of out-of-network claims;
- requests for a referral to an out-of-network provider because of limited network providers,[7] including referrals granted, claims received for which a referral was requested and claims for which a referral was granted, single-case agreements that were requested and entered for out-of-network providers, and related claims information;
- complaints received related to access or availability of providers, including enrollee and provider complaints related to wait time and travel distance, directory accuracy, dollar amount of reimbursement for out-of-network claims, including balance billing, and percentage of complaints related to the federal No Surprises Act; and
- a description of telehealth utilization based on the total number and percentage of telehealth claims for all provider/facility types and for each county.

COMAR § 31.10.44.04.C. Finally, carriers are required to disclose, among other items, information about their practices to assist enrollees requesting out-of-network services when a network provider is

[6] The carrier's chart must also include a note stating: "*As permitted by Maryland regulations, a telehealth mileage credit was applied to up to 10 percent of enrollees for each provider type with an asterisk in each of the urban, rural or suburban geographical areas. The mileage credit is 5 miles for urban areas, 10 miles for suburban areas, and 15 miles for rural areas."*

[7] Maryland law allows plan enrollees to request a referral to an out-of-network specialist or nonphysician specialist if a practitioner with the training and expertise to treat the condition is not in the network or a practitioner is not available within a reasonable time and distance. INS. § 15-830(d)(1). The law bars "balance billing" for enrollees who receive approval to see an out-of-network provider for SUD or MH services; the carrier must cover such services at "no greater cost" to the enrollee than if the benefit were provided by a network provider. INS. § 15-830(e)(2).

not available, appointment management systems, and efforts to assist enrollees who are unsuccessful in using the provider directory to identify appropriate providers.

While specific portions of the access plan are deemed confidential, 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 upon request. COMAR § 31.10.44.10.A and Attorney General's Certification, 44 MD REG 1171, 1182 (Dec. 8, 2017).

Network Adequacy Waiver Requirements

For any travel distance, appointment wait time, or provider-patient ratio metric that the carrier's network fails to satisfy (taking into consideration any approved telehealth credit), the carrier must submit, in its annual access plan, (1) an estimate of the number of providers or facilities that it would need to include in its network to satisfy the unmet metric(s) and (2) a detailed description of its efforts to contract with providers that would fill the gaps. The carrier is required to provide, among other information:

- list of providers and facilities with whom the carrier attempted to contract, description of the time and method of contact, and reasons given for refusing to contract;
- analysis of the reasons given for refusal to contract and the carrier's plans to address and improve future contracting;
- identification of all incentives the carrier offers to providers to join the network;
- a substantiated statement that an insufficient number of providers are available in the service area to meet the metrics, if applicable; and
- steps taken over the past year to enhance its network and address deficiencies that contributed to each unmet metric and steps the carrier will take to avoid a future failure to meet a metric.

The MIA may grant the carrier a waiver of one or more standards for one year. The MIA must find 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;
- are unable to reach agreement with the carrier; or
- the failure to meet a standard results from the measurement methodology and not a network deficiency.

COMAR § 31.10.44.09.A and B. **The MIA will post a list of all waivers that it grants annually on its website.** COMAR § 31.10.44.09.C.

Strong Enforcement of Network Adequacy Standards Will Help Regulators and Policy-Makers Ensure Prompt Access to Substance Use Disorder and Mental Health Care

Maryland's new network standards will allow state regulators and legislators to identify network gaps for SUD and MH providers and understand the source of such gaps – whether based on contracting practices, reimbursement rates, administrative barriers, or insufficient workforce. Carrier data that must be submitted in annual access plans will also support enforcement of other state and federal law protections. For example:

- Disparate rates of access to SUD and MH network providers and services and out-of-network utilization for SUD and MH providers and services compared to medical/surgical data may reflect a Parity Act violation in the carrier's practices for network inclusion, contracting or reimbursement rates.
- Data on rates of referrals to out-of-network providers and single case agreements for SUD and MH providers will support an assessment of whether carriers are complying with protections under INS. § 15-830(d) and (e), and disparate rates for SUD, MH and medical services may reflect an underlying Parity Act violation.
- Compliance data may reveal additional limitations on SUD and MH treatment that violate the Parity Act.

To ensure that carrier data is used to improve consumer access to care going forward, we call upon the MIA to:

- **Issue annual public reports** that summarize carrier practices and aggregate data from access plans and lessons learned from network adequacy waiver information to guide the General Assembly, the public and other policymakers on future policy reform.
- **Closely monitor carrier telehealth practices** to ensure true consumer choice in accessing in-person, telehealth or hybrid SUD and MH services.
- **Use the network adequacy data to enforce the Parity Act** and other state consumer protection laws, including access to out-of-network services for SUD and MH care without greater costs when provider networks are inadequate.

State and federal policymakers and regulators recognize that robust provider networks are the linchpin to care access and delivery. Significant attention has focused on the availability of SUD and MH services because of the unprecedented opioid epidemic and mental health crisis, particularly affecting youth and young adults, and more limited access to network services. Strong enforcement of network adequacy and Parity Act standards is needed to ensure that consumers gain prompt access to life-saving care and are not forced to endure long wait-times for a qualified network provider, pay significant out-of-pocket costs for services that should be available through a network provider, or, tragically, forgo care.

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