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July 27, 2022

Director of Regulatory Affairs
Maryland Insurance Administration
200 St. Paul Street, Suite 2700
Baltimore, MD 21202

Dear Director of Regulatory Affairs:

The Community Behavioral Health Association of Maryland (CBH) is the leading voice for community-based providers serving the mental health and addiction needs of vulnerable Marylanders. Our 105 members serve the majority of those accessing care through the public behavioral health system but also serve those covered by private insurance. CBH members provide outpatient and residential treatment for mental health and addiction-related disorders, day programs, case management, Assertive Community Treatment (ACT), and crisis intervention.

We appreciate the opportunity to comment on the proposed Network Adequacy (31.10.44) regulations. CBH commends the Maryland Insurance Administration (MIA) for its work in ensuring that those with commercial insurance have timely access to behavioral health care. The proposed regulations address many of the issues raised about access to behavioral health services by providers and consumers during numerous MIA listening sessions. We appreciate MIA's focus on behavioral health and its response to our collective concerns.

Travel Distance and Wait Time Standards

CBH strongly supports the MIA's addition of travel distance standards for behavioral health practitioners and services, including child and geriatric psychiatry, licensed professional counselors, outpatient mental health centers (OMHCs), and outpatient substance use disorder (SUD) programs and facilities. The proposed regulations standardize the methodology for determining carrier compliance with travel distance and for the reporting of same. We believe this is critical to ensuring that carriers in actuality have sufficient networks of behavioral health providers and that consumers can make informed choices when choosing a carrier.

We are also very supportive of the inclusion and separate reporting of appointment wait time standards for urgent and non-urgent inpatient and outpatient mental health and SUD care, and of language specifying that the appointment must be with "a provider possessing the appropriate skill and expertise to treat the condition." Consumers often face significant wait times for behavioral health services, particularly for specialized care such as child psychiatry. Long wait times can lead to worsening symptoms and functionality, sometimes resulting in hospitalization or suicide. Individuals –



or their family members – are forced to enter into private pay arrangements in which they reimburse the practitioner and subsequently try to negotiate some level of reimbursement from their carrier. Of course, not everyone can afford to pay out-of-pocket for their care and so are left waiting for an appropriate in-network practitioner. Consumers should not be forced to subsidize behavioral health services they pay premiums to have access to.

CBH is particularly gratified to see the inclusion of travel distance standards specific to residential crisis services (RCS). RCS are designed to provide an alternative to emergency department (ED) and inpatient utilization for those experiencing, or at imminent risk of, a psychiatric emergency, or to shorten an inpatient length of stay. The aim is to provide the same level of psychiatric care but in an environment that is less chaotic and triggering for those experiencing psychiatric decompensation.

RCS has been a mandated benefit in commercial insurance products for over 20 years, but our providers report few contracts with carriers and a lack of referrals from those that do contract with them. This is despite clear evidence that hospital EDs are struggling with utilization by those with behavioral health conditions. According to the Maryland Hospital Association, from 2016-2020, ED utilization for behavioral health conditions rose by 12% while ED visits for all other conditions fell by 11%. And in a January 2022 presentation to the Maryland Health Care Commission, the Maryland Institute for Emergency Medical Services System (MIEMSS) presented data showing that psychiatric patients accounted for 25% of ED boarders but 68% of ED boarding time (based on a ten-day analysis from November of 2021). This suggests that there are specific challenges to finding prompt and appropriate placements for psychiatric patients who are no longer in need of ED services, or interventions that could avert the need for an ED visit. RCS provides a safe and effective alternative to many individuals in need of crisis stabilization.

We believe the travel distance guidelines in the proposed regulations will encourage carriers to meet their statutory requirement to provide RCS, will help alleviate the preventable utilization of EDs for psychiatric crises, will further help reduce inpatient lengths of stay, and provide a calmer and more therapeutic milieu for those experiencing a psychiatric crisis.

Reporting Requirements on Out-of-Network (OON) Claims

The new reporting requirements on OON claims are another addition to the proposed regulations that are strongly supported by CBH. Two studies by Milliman indicated that Maryland has one of the worst records in the nation for its overuse of OON providers for behavioral health services. The impact on consumers can be significant in terms of cost sharing and delays in, or forgoing of, treatment. And although the passage of SB 707/HB 912 during the 2022 legislative session may shield consumers from additional out-of-pocket expenses when accessing behavioral health services from an OON provider, it remains to be seen how well consumers will be informed of that protection, which is only slated to last until June 30, 2025, when the legislation sunsets. The use of OON providers is a strong indicator that a carrier's network may be inadequate. Reporting on OON utilization will help identify areas needing attention.

Telehealth

CBH also appreciates the balance the MIA has brought to the use of telehealth and its use in meeting network adequacy standards. We recognize the critical importance of continuing the current flexibility to use telehealth but believe that in-person services must also be readily available, particularly for behavioral health care. Unlike visits for somatic conditions that involve a visual examination, or one done via monitoring equipment, behavioral health practitioners must rely on their client’s willingness to disclose their innermost thoughts and feelings. This requires the client’s trust in both the practitioner and the mode of service delivery. It is critically important to the therapeutic relationship that clients feel at ease to discuss matters of great privacy. Some may not feel comfortable with a visit conducted via telehealth for that reason. Others may feel a greater sense of connectedness with in-person visits. We therefore suggest that carriers be required to ask those members seeking a behavioral health visit to indicate their consent to do so via telehealth. We also suggest that “clinically appropriate” be defined to include a client’s willingness to engage in telehealth, at least for behavioral health services.

Definitions

Finally, we raise a point of clarification. The proposed regulations [.02 B. (6)] define “drug and alcohol treatment program” as “any organization or individual certified by the Maryland Department of Health in accordance with Title 10, Subtitle 47 of COMAR.” Our understanding is that the 10.47 regulations were replaced by the adoption of the 10.63 regulations, which created the Behavioral Health Administration, and are the vehicle for determining licensure or certification of SUD programs.

In closing, CBH strongly supports the proposed regulations on Network Adequacy and looks forward to working with the MIA and insurance carriers to ensure timely access to clinically appropriate behavioral health care.

Sincerely,

Sincerely,



Shannon Hall, J.D.
Executive Director

cc: Lori Doyle, Public Policy Director