The Maryland Women's Coalition for Health Care Reform, and the 36 undersigned organizations, appreciates the opportunity to comment on the CMS Draft letter to Issuers in the Federally-facilitated Marketplaces (FFM) released on February 4, 2014. This sets forth proposals for 2015 standards applicable to plans offered on the FFM.

As a state-based marketplace, the Maryland Health Benefit Exchange (MHBE) took what it called a "balanced and incremental approach for its carrier contracting strategy." While the Coalition recognizes the MHBE's stated reasons for this approach, the undersigned have had concerns that these decisions have not always been the most advantageous for consumers purchasing insurance at Maryland Health Connection. In reviewing the CMS letter it is clear that Maryland consumers may, in fact, be at a disadvantage over residents in FFM states due to the stronger consumer protections in a number of areas. The stronger federal standards recognize that the goal of the Affordable Care Act is to provide access to high-quality, affordable access to care not just an insurance card. Maryland has a precedent of exceeding the Federal minimum standards in order to achieve this goal, including the selection of one of the most robust Essential Health Benefit Plans. To find that we have lower standards in several areas leads us to provide the recommendations cited in this letter. These will better align us with FFM states and, in so doing, improve access to high-quality, comprehensive and affordable care for our state's residents.

ADDENDUM [17 March 2014]: As per approval from Carolyn Quattrocki, MHBE Interim Executive Director, we are submitting the following additional signatories to our comments. These include the following seven organizations: Unitarian Universalist Legislative Ministry of Maryland; Planned Parenthood of Metro Washington; On Our Own of Maryland, Inc., Maryland Psychological Association; Progressive Cheverly; Sisters Together and Reaching (STAR); Maryland Clinical Social Work Coalition of the Greater Washington Society for Clinical Social Work.

In addition, we would point out that on March 14, 2014, CMS in its 2015 Letter to Issuers in the Federally-Facilitated Marketplaces codified many of the more stringent standards that were included in the CMS letter of February 4th upon which our recommendations are predicated. (Attached is the March 14 letter) While we have not had an opportunity to review this in detail, it is clear that CMS responded to consumers' concerns in areas that include network adequacy, drug formularies and Essential Community Providers. As we have in the past, we encourage

the MHBE to take the opportunity to exceed the Federal standards for plan certification to reflect the complex needs of Marylanders. In so doing, it can assure them access to high-quality and comprehensive benefit plans that fully meet their needs.

We would also note that we strongly endorse the letter submitted by the Health Education and Advocacy Unit of the Office of the Attorney General. In particular, we would draw your attention to their comments on the QHP Plan Certification Process and the Summary of Benefits and Coverage. While we did not comment on these specifically in the following, we believe that the issues raised in their letter are worth all due consideration.

For further information contact: Leni Preston, Chair, Maryland Women's Coalition for Health Care Reform – leni@mdchcr.org

Advocates for Children and Youth
Baltimore Healthy Start
Community Behavioral Health Association of Maryland
Institutes for Behavior Resources, Inc/REACH Health Services
League of Women Voters
Maryland Assembly on School-Based Health Centers
Maryland Association of Core Service Agencies
Maryland Citizens Health Initiative
Maryland Dental Action Coalition
Mental Health Association of Maryland
Montgomery County Dept. of Health & Human Services
National Alliance on Mental Illness (Maryland and 12 County Chapters)
National Council on Alcoholism and Drug Dependence
Planned Parenthood of Maryland
Primary Care Coalition of Montgomery County
Public Justice Center
University of Maryland Carey School of Law, Drug Policy and Public Health Strategies Clinic

The chart below includes our recommendation, which were informed by the following documents:

CMS: **Draft 2015 Letter to Issuers in the Federally-facilitated Marketplaces, February 4, 2014**

2015 Plan Certification Standards, Report to MHBE Board Meeting, Carolyn Quattrocki, February 18, 2014

Maryland Health Benefit Exchange Carrier Reference Manual, Release 2.0 June 2013; Maryland Health Benefit Exchange Carrier and Qualified Plan Certification, Interim Procedures (Also included in Carrier Reference Manual, Appendix C)

Maryland Health Benefit Exchange Board of Trustees Statement of Policy Regarding Essential Community Providers and Network Adequacy (Also included in Carrier Reference Manual, Appendix E); Supplementary Response: Inclusion of Essential Community Providers

Issue Area	CMS Proposal	Recommendation
Qualified Health Plan & Stand-Alone Dental Plan Certification Standards: **B.8-10. Network Adequacy**	Plans will be required to submit complete provider lists as part of QHP applications, and CMS will evaluate whether the network will provide access to services for all enrollees without unreasonable delay;	We believe that the **CMS proposal is a good start and should be adopted by the MHBE. However**, we believe that both CMS regulations and those for the **MHBE specifically should go further.** The MHBE Plan Management Advisory Committee discussed this issue at length. At that time, many organizations recommended that the MHBE develop specific network adequacy standards using the Maryland Medical Assistance Program standards as a starting point and then explore what changes would make sense for QHPs. Here are **several components of network adequacy requirements that we find essential**: • Conduct an assessment and develop specific standards for how many primary care providers are needed for the population enrolled. Primary care providers should include physicians and non-physicians. In assessing and developing these standards, MHBE should look at different categories of primary care, including pediatrics, family medicine, and women's health, including ob/gyn providers. It is important to note that for many women, their ob/gyn provider is their primary care provider and is sanctioned under the ACA. • As mental health and substance use disorder services are specifically mentioned in the Affordable Care Act and CMS is proposing to focus on these services for targeted network adequacy reviews, MHBE should conduct an assessment of behavioral health providers and develop specific standards for how many behavioral health providers, both mental health and substance use disorder providers, are needed for the enrolled population. Behavioral health providers must include physicians and non-physicians and include programs that have traditionally served low-income and underserved populations to ensure continuity of care. The standards should also address the need for a sufficient number of providers for specific populations of enrollees, such as children,

Issue Area	CMS Proposal	Recommendation
		adolescents, and the aging. • Conduct an assessment and develop specific standards for how many specialty providers are needed for the population enrolled. Specialty providers should include physicians and non-physicians and there should be a sufficient number of providers for specific populations of enrollees, including adolescents and women. • Develop meaningful standards such as number of providers who are taking new patients, wait time for appointments, and travel time to appointments to ensure that providers are accessible to enrollees. • Develop clear and consistent reporting requirements within the plan year so that network adequacy can be monitored quarterly and reported to the MHBE Board and adjustments to standards can be made if needed for the following plan year. In this regard we would encourage maximum transparency and access to the information on network adequacy. This should include the MHBE's performance measures and its required quarterly "access to care" reports. This information will be of use both to consumers as well as other stakeholders, including consumer advocates, who can then identify areas of concern that should be addressed in the future.
Qualified Health Plan & Stand-Alone Dental Plan Certification Standards:	Plans will be required to have 30% of ECPs in the service area in their networks (as opposed to current 20% requirement)	We recommend that the MHBE **develop a stronger ECP policy**. The **CMS proposal is inadequate** and will leave enrollees without access to a significant number of ECPs. We believe that **QHPs should include a high number of ECPs because ECPs historically serve the Medicaid and uninsured population**. The inclusion in ECPs in QHP networks will help mitigate the impact of the churn between the QHPs and Medicaid. MHBE should set policies that help ensure the ECP participation in QHP

Issue Area	CMS Proposal	Recommendation
C.11. Essential Community Providers (ECP)		networks mirror their participation on the Medicaid program. **To meet this goa**l, we recommend: • A **full assessment of ECP participation in current QHP networks**. While we understand this is a requirement now, we want to make sure that the MHBE has the data and resources to make a meaningful assessment; • **Careful consideration of expanding the definition of ECP beyond the federal definition**. There are several types of providers that are not categorically included in the federal definition, including behavioral health providers, Title X Look Alike Family Planning Clinics, and school-based health centers. If we do not expand the ECP definition in Maryland, we miss the opportunity to use the ECP requirement as a tool to ensure network adequacy for populations which continue to be underserved. • We **do not endorse a specific percentage threshold for ECP participation at this time**, as the MHBE has not yet provided data on current ECP participation in networks. We also believe that the **percentage of ECP participation should be** closer to 100% in order to ensure access for populations that have been historically uninsured or underinsured and who have long-standing relationships with trusted providers, such as Ryan White Providers. .
Qualified Health Plan & Stand-Alone Dental Plan Certification Standards: **C.12. ECP**	Plans will also be required to offer at least one contract to each type of ECP in each county in service area, and to any Indian health provider	We **do not endorse the CMS proposal and urge the MHBE to start with Maryland's existing standard and assess how to make that standard more effective**. If there is more than one ECP in a category of ECPs in a jurisdiction, then allowing plans to meet ECP requirements by contracting with just one ECP in a category could have a profoundly negative effect on access to ECPs, who are historical safety net providers. For example, there could be several federally qualified health centers in one jurisdiction. By allowing plans to meet ECP requirements by contracting with just one of these providers, we would be eliminating access to QHP enrollees to their historical providers. Therefore we **strongly oppose adopting the CMS**

Issue Area	CMS Proposal	Recommendation
		recommendation and urge Maryland to continue to assess and improve the Maryland ECP standard.
Qualified Health Plan & Stand-Alone Dental Plan Certification Standards: **C.13. ECP**	Plans not meeting standard may demonstrate how network provides adequate service for low income and medically underserved individuals, and how they intend to increase ECP participation.	We question whether a QHP could have met network adequacy requirements without having high participation of ECPs in its network. **Therefore, we do not think there should be a waiver option for those QHPs that do not meet ECP requirements**.
Qualified Health Plan and Stand-Alone Dental Plan Design: **B.17. Prescription Drugs**	Drugs covered under plan's medical benefit must be identified in plan's filings;	We recommend **aligning MHBE's Carrier Manual and policies to adopt this proposal.** It will have a direct and positive impact on consumers, especially those with chronic illness as out of pocket costs for medications may be their most expensive health care cost.

Issue Area	CMS Proposal	Recommendation
Qualified Health Plan and Stand-Alone Dental Plan Design: **B.17. Prescription Drugs**	Drug formulary Internet link provided by plans must link directly to list of covered drugs without requiring further navigation, and must include tiering and cost-sharing.	We **recommend aligning MHBE's Carrier Manual and policies to include this requirement** as QHP formularies are not available consistently through a direct link. Carriers should also be required to provide in their formulary list information regarding all authorization and step-therapy requirements as well as cost-sharing requirements. Consumers' ability to easily access information on drug formularies will lead to wiser decision making and improved health outcomes.
Qualified Health Plan and Stand-Alone Dental Plan Design: **B.20. Prescription Drugs**	CMS will permit states to require plans to cover non-formulary drugs, including drugs that are on formulary but require prior authorization or step therapy, for first 30 days of new coverage under a QHP to prevent disruptions in treatment; and	We endorse the CMS recommendation as a way to strengthen the relevant continuity of care statutory language in the Maryland Health Progress Act of 2013. We note that this provision is important for the treatment of many chronic diseases, including HIV/AIDs, and for ensuring consistent access to the most effective forms of contraception.
Qualified Health Plan and Stand-Alone Dental Plan Design: **A.14.**	CMS will continue to use outlier analysis for determining whether benefit design discriminates against individuals with significant health needs.	While MHBE policy does address non-discriminatory benefit design, we believe it should go farther. MHBE should explicitly state in its Carrier Manual and policies that it will use outlier analysis for determining whether benefit design discriminates against individuals with significant health needs. MIA must develop a comprehensive methodology for reviewing plan compliance with the Mental Health Parity and Addiction Equity Act, including both quantitative treatment limitations and non-quantitative treatment limitations, so that MHBE will

Issue Area	CMS Proposal	Recommendation
Discriminatory Benefit Design		certify only those plans that comply with the Parity Act. The MIA's methodology should identify the specific documentation carriers must submit to demonstrate parity compliance for all plans. This methodology and process should be transparent for consumers and providers. A review of publicly available plan documents for QHPs indicates that carriers have not provided sufficient information to demonstrate compliance with the Parity Act, (particularly with regard to non-quantitative treatment limitations) and raises strong questions as to whether the MIA adequately reviewed plan compliance with the Parity Act. We also ask that the MHBE add "pregnancy and newborn care" back to the list of specific benefits it will assess. CMS had originally designated this in the list of benefits to be assessed in its 2014 letter, but CMS has removed it in its 2015 letter. Given that women continue to face barriers to obtaining pre-natal care and Maryland's policy emphasis on improving health outcomes for newborns, such as reducing the incidents of low-birth weight babies, it is critical that we assess benefits for pregnancy and newborn care.
Qualified Health Plan and Stand-Alone Dental Plan Design: **A.15. Discriminatory Benefit Design**	Will focus particularly on plans with unusually large number of drugs subject to prior authorization and/or step therapy in a category or class;	We recommend that this be explicitly included as part of MIA Certification of Plans process.

Issue Area	CMS Proposal	Recommendation
Qualified Health Plan and Stand-Alone Dental Plan Design: **D.25. Primary Care**	CMS is considering future requirement that all plans, or at least one at each metal level, cover three primary care office visits a year not subject to deductible.	**We recommend that this provision be adopted by the MHBE for all plans.** It is in line with incentivizing preventive care and could have the positive effect of an established relationship between the primary care medical doctor and/or dental provider, and the consumer. In an effort to reduce costs and enable consumers to attain the least intensive level of care, primary care visits should be encourage and incentivized.
Qualified Health Plan and Stand-Alone Dental Plan Design: **C.21. Meaningful Difference**	CMS will continue to evaluate whether multiple plans offered by same issuer are meaningfully different before certifying them;	We support the intent to ensure that there is a meaningful difference in the plans prior to certification.
Qualified Health Plan and Stand-Alone Dental Plan Design: **C.22.Meaningful Difference**	Factors to be considered are plans' networks, formularies, deductibles, out-of-pocket limits, covered benefits, premiums, health savings account eligibility, and differences in child-only, and family coverage.	We believe that consumers must be made aware of these factors at the time of plan selection. Without this information they will be unable to ensure that they are selecting the right plan for themselves and their families.

Issue Area	CMS Proposal	Recommendation
Qualified Health Plan & Stand-Alone Dental Plan Certification Standards: **A.6. Service Areas**	Will permit service area changes after initial data submission for limited reasons, e.g. issuer's inability to secure enough providers; state or CMS request to expand to serve and unmet need.	We **recommend that the MHBE adopt the CMS recommendation**. For those QHPs with inadequate providers in a specific service area they should be required to pull out of that area until such time as they can include an adequate number of providers. In addition, QHPs could be provided the option of alternate service areas if they had evidence of sufficient providers there.
Consumer Support and Related Issues: **32. Meaningful Access for Individuals with Limited English Proficiency**	CMS to issue additional regulations to address access to certain documents, including applications, grievance forms, and explanations of benefits.	MHBE should **develop a Language Access Plan** that includes specific strategies to ensure meaningful access for individuals with Limited English Proficiency and low health literacy. In addition, MHBE should endeavor to complete and make available Spanish documentation and information in other key languages spoken by Maryland consumers in as timely a fashion as possible.

At the Board Meeting on February 18, Ms. Quattrocki presented a list of issues for which public comment would be solicited. At that time the CMS proposals for provider directory were included in that request. However, they were not included in the list posted on the MHBE website for comment. While this may well be because of the work being done with CRISP, we felt it important to include our recommendations and do so below:

Issue Area	CMS Proposal	Recommendation
Provider Directory	Plans will be required to provide a direct link to provider directories that do not require further navigation or logging in	MHBE should accomplish this by **integrating the CRISP provider directory link in the MHC website**. MHBE should also work with CRISP, carriers, consumers, and providers to identify methods to ensure provider directories are up to date.
Provider Directory	Directories must include location, contact information, specialty, medical group, institutional affiliation, and whether provider is accepting new patients;	CRISP has incorporated some of these elements into its provider directory. It is currently making improvements in identifying **specialty, and medical group or community health center listing**. Community health centers include but are not limited to federally qualified health centers, mental health providers, substance use disorder providers, family planning provider, Ryan White Providers, and school-based health centers. We believe that these should be **required elements** in the database and also endorse the inclusion of whether the provider is accepting new patients. In addition to including the institutional affiliation of the practitioner, the Provider Directory should also include dental providers and practices, as well as the name of each substance use disorder and mental health treatment program that has practitioners in a carrier's network so that consumers may search for a provider by the program's name. Carriers should be required to adopt a uniform and consumer-oriented taxonomy for clinical specialties that encompass physician and non-physician practitioners for the full range of health services, including oral and behavioral health specialties.
Provider Directory	Plans encouraged also to include language spoken, credentials, and whether provider is Indian provider.	We strongly recommend that the **criteria identified by CMS be included for all QHPs** as they will contribute to the consumer finding culturally appropriate care.