BEFORE THE MARYLAND INSURANCE ADMINISTRATION

MARYLAND INSURANCE ADMINISTRATION 200 ST. PAUL PLACE, SUITE 2700 BALTIMORE, MARYLAND 21202	*	
vs.	*	
CAREFIRST BLUECHOICE, INC. 840 FIRST ST., NE WASHINGTON, DC 20065	*	CASE NO: MIA-2021-05-016
NAIC# 96202	*	

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CONSENT ORDER

This Consent Order is entered into by the Maryland Insurance Commissioner and CAREFIRST BLUECHOICE, INC. ("BlueChoice" or "Respondent") pursuant to §§ 2-108 and 2-204 of the Insurance Article, and § 19-730 of the Health-General Article, Maryland Code Annotated, to resolve the matter before the Maryland Insurance Administration ("Administration").

I. RELEVANT REGULATORY FRAMEWORK

1. Each health maintenance organization ("HMO") that uses provider panels for health benefit plans offered in the State must assure that its provider panels meet certain adequacy standards. On July 1 of each year each HMO is required to file a report with the Administration demonstrating the HMO's compliance with those standards.

2. §15-112 of the Insurance Article provides, in pertinent part:

(a) (1) In this section the following words have the meanings indicated.

* * *

(5) (i) "Carrier" means:

* * *

3. a health maintenance organization;

(b) (1) Subject to paragraph (3) of this subsection, a carrier that uses a provider panel shall:

(i) if the carrier is an insurer, nonprofit health service plan, health maintenance organization, or dental plan organization, maintain standards in accordance with regulations adopted by the Commissioner for availability of health care providers to meet the health care needs of enrollees;

* * *

(c) (1) This subsection applies to a carrier that:

(i) is an insurer, a nonprofit health service plan, or a health maintenance organization; and

(ii) uses a provider panel for a health benefit plan offered by the carrier.

(2) (i) On or before July 1, 2018, and annually thereafter, a carrier shall file with the Commissioner for review by the Commissioner an access plan that meets the requirements of subsection (b) of this section and any regulations adopted by the Commissioner under subsections (b) and (d) of this section.

3. The regulations referenced in § 15-112(c)(2)(i) of the Insurance Article are set forth in COMAR 31.10.44.

4. The network adequacy standards are set forth in COMAR 31.10.44.04 -.06 and consist of travel distance standards (COMAR 31.10.44.04), appointment waiting time standards (COMAR 31.10.44.05), and provider-to-enrollee ratio standards (COMAR 31.10.44.06) (collectively, the "Standards").

5. The access plan content and filing requirements are set forth in COMAR 31.10.44.03, which provides, in pertinent part:

.03 Filing of Access Plan.

C. Each annual access plan filed with the Commissioner shall include:

(1) An executive summary in the form set forth in Regulation .09 of this chapter;

(2) The information and process required by Insurance Article, §15-112(c)(4), Annotated Code of Maryland, and the methods used by the carrier to comply with the monitoring requirement under §15-112(c)(5);

(3) Documentation justifying to the Commissioner how the access plan meets each network sufficiency standard set forth in Regulations .04—.06 of this chapter; and

(4) A list of all changes made to the access plan filed the previous year.

6. COMAR 31.10.44.07 allows a carrier to apply for a temporary waiver from compliance with one or more of the Standards provided that certain criteria are met.

II. **FINDINGS**

7. BlueChoice holds a Certificate of Authority to act as a HMO in the State and uses provider panels for health benefit plans offered in the State. As such, it is subject to § 15-112 of the Insurance Article and the network adequacy standards set forth in COMAR 31.10.44.04 - .06. In addition, BlueChoice is required to file a network adequacy plan in accordance with COMAR 31.10.44.03.

8. On July 1, 2019, CareFirst BlueCross BlueShield submitted a Network Adequacy Plan (the "BC 2019 Access Plan") to the Administration on behalf of BlueChoice.

9. On the same date, BlueChoice requested a waiver of the Appointment Wait Time Standards (the "Waiver Request"). The Waiver Request set forth proprietary and confidential information explaining the basis for the Waiver Request and describing the steps BlueChoice had taken and planned to take to attempt to improve its network to meet this standard and to avoid future waiver requests as to this standard.

10. On October 29, 2019, the Administration issued an Order against BlueChoice (the "Initial Order") finding that the BC 2019 Access Plan failed to include all

of the information and documentation required by § 15-112 of the Insurance Article, COMAR 31.10.44.03, and COMAR 31.10.44.09. On the same date, the Administration directed BlueChoice by letter to submit additional information necessary for the Administration to evaluate whether BlueChoice was in compliance with the Standards.

11. On November 7, 2019, BlueChoice requested a hearing to contest the Initial Order.

12. The Administration thereafter agreed with BlueChoice that if, within 60 days of the Initial Order, BlueChoice provided the additional information requested in both the Initial Order and the October 29, 2019 letter, the hearing request would be withdrawn, the Administration would continue its review of the BC 2019 Access Plan, and upon completion of the BC 2019 Access Plan review, the Initial Order would be rescinded.

13. On December 27, 2019, BlueChoice submitted the additional information. The information included a revised executive summary form and several proprietary and confidential items, including details of the methodology BlueChoice used to measure and assess its performance in meeting the network adequacy standards and the factors BlueChoice used to build its network. The information also contained proprietary and confidential material intended to supplement the Waiver Request, including a description of outreach efforts to contract with providers and additional details regarding BlueChoice's efforts to improve its network.

A. <u>The Waiver Request</u>

14. The criteria that must be met in order to qualify for a waiver of a Standard are set forth in COMAR 31.10.44.07, which states, in pertinent part:

.07 Waiver Request Standards

A. A carrier may apply for a network adequacy waiver, for up to 1 year, of a network adequacy requirement listed in this chapter.

B. The Commissioner may find good cause to grant the network adequacy waiver request if the carrier demonstrates that the physicians, other providers, or health care facilities necessary for an adequate network:

(1) Are not available to contract with the carrier;

(2) Are not available in sufficient numbers;

(3) Have refused to contract with the carrier; or

(4) Are unable to reach agreement with the carrier.

C. A carrier seeking a network adequacy waiver shall submit a written request to the Commissioner that includes the following information:

* * *

(2) A list of physicians, other providers, or health care facilities within the relevant service area that the carrier attempted to contract with, identified by name and specialty, if any, or health care facility type;

(3) A description of how and when the carrier last contacted the physicians, other providers, or health care facilities;

(4) A description of any reason each physician, other provider, or health care facility gave for refusing to contract with the carrier;

(5) Steps the carrier will take to attempt to improve its network to avoid future network adequacy waiver requests;

15. The Waiver Request failed to include the information required by COMAR 31.10.44.07C(2)-(4). Even after additional information was provided on December 27, 2019, the Waiver Request failed to demonstrate that the physicians, other providers, or health care facilities necessary for an adequate network: were not available to contract

with the carrier; were not available in sufficient numbers; refused to contract with the carrier; and/or were unable to reach agreement with the carrier.

16. Because BlueChoice failed to satisfy the criteria for a waiver as set forth in COMAR, its Waiver Request must be denied.

B. The Access Plan-Travel Distance Standards

17. The data submitted by BlueChoice in connection with the BC 2019 Access Plan failed to demonstrate compliance with the Travel Distance Standards.

18. COMAR 31.10.44.04 provides, in pertinent part:

.04 Travel Distance Standards

A. Sufficiency Standards.

> (1) Except as stated in §B of this regulation, each provider panel of a carrier shall have within the geographic area served by the carrier's network or networks, sufficient primary care physicians, specialty providers, behavioral health and substance use disorder providers, hospitals, and health care facilities to meet the maximum travel distance standards listed in the chart in §A(5) of this regulation for each type of geographic area. The distances listed in §A(5) of this regulation shall be measured from the enrollee's place of residence.

* * *

(5) Chart of Travel Distance Standards.

	Urban Area Maximum Distance (miles)	Suburban Area Maximum Distance (miles)	Rural Area Maximum Distance Miles
Provider Type:			

* * *

Allergy and Immunology	15	30	75

* * *

Gynecology, OB/GYN	5	10	30
Gynecology Only	15	30	75

* * *

Facility Type:			
Acute Inpatient Hospitals	10	30	60
Critical Care Services – Intensive Care Units	10	30	100

* * *

Outpatient Infusion/ Chemotherapy	10	30	60

19. The data self-reported by BlueChoice disclosed the following deficiencies based on distance of a provider to an enrollee's address:

(a) Allergy and Immunology providers met the required standard for 99.1% of suburban enrollees, leaving 1054 enrollees outside of the travel distance standard of thirty miles in one zip code, 21842.

(b) Gynecology, OB/GYN providers met the required standard for 99.9% of urban enrollees, leaving 101 enrollees outside of the travel distance standard of five miles in two zip codes. The standard was met for 99.6% of suburban enrollees, leaving 518 enrollees outside of the travel distance standard of ten miles in four zip codes.

Urban zip codes:

(i) Zip code 21403 has 70 members outside the standard.
(ii) Zip code 21052 has 31 members outside the standard.

Suburban zip codes:

(i) Zip code 20764 has 156 members outside the standard.
(ii) Zip code 21913 has 17 members outside the standard.
(iii) Zip code 20625 has 71 members outside the standard.
(iv) Zip code 21716 has 274 members outside the standard.

(c) Gynecology Only providers met the required standard for 99.7% of suburban enrollees, leaving 385 enrollees outside of the travel distance standard of thirty miles in three zip codes.

Suburban zip codes:

(i) Zip code 21664 has 36 members outside the standard.
(ii) Zip code 20686 has 21 members outside the standard.
(iii) Zip code 21842 has 328 members outside the standard.

(d) Acute Inpatient Hospitals facilities met the required standard for 99.8% of urban enrollees, leaving 284 enrollees outside the travel distance standard of ten miles in three zip codes.

Urban zip codes:

(i) Zip code 21114 has 202 members outside the standard.
(ii) Zip code 21052 has 31 members outside the standard.
(iii) Zip code 21040 has 51 members outside the standard.

(e) Critical Care Services facilities met the required standard for 99% of urban enrollees, leaving 1,356 enrollees outside the travel distance standard of ten miles in four zip codes.

Urban zip codes:

(i) Zip code 21114 has 879 members outside the standard.
(ii) Zip code 21040 has 436 members outside the standard.
(iii) Zip code 21734 has 39 members outside the standard.
(iv) Zip code 21746 has 2 members outside the standard.

(f) Outpatient Infusion/Chemotherapy facilities met the required standard for 72.1% of urban enrollees, leaving 37,133 enrollees outside the travel distance standard of ten miles in twenty-seven zip codes. The standard was met for 95.1% of suburban enrollees, leaving 6,026 enrollees outside the travel distance standards of thirty miles in thirteen zip codes. The standard was met for 99.8% of rural enrollees, leaving 193 enrollees outside the travel distance standard of sixty miles in four zip codes.

Urban zip codes:

(i) Zip code 21402 has 18 members outside the standard.
(ii) Zip code 21403 has 2,644 members outside the standard.
(iii) Zip code 21114 has 2,206 members outside the standard.
(iv) Zip code 21228 has 41 members outside the standard.
(v) Zip code 21052 has 31 members outside the standard.
(vi) Zip code 21040 has 1,121 members outside the standard.
(vii) Zip code 20814 has 1,955 members outside the standard.
(viii) Zip code 20816 has 969 members outside the standard.
(ix) Zip code 20815 has 1,535 members outside the standard.
(x) Zip code 20877 has 2,134 members outside the standard.
(xi) Zip code 20879 has 1,887 members outside the standard.
(xii) Zip code 20886 has 2,317 members outside the standard.
(xiii) Zip code 20850 has 3,906 members outside the standard.
(xiv) Zip code 20851 has 1,142 members outside the standard.
(xv) Zip code 20852 has 1,983 members outside the standard.
(xvi) Zip code 20853 has 1,840 members outside the standard.
(xvii) Zip code 20906 has 816 members outside the standard.

(xviii) Zip code 20743 has 1,723 members outside the standard.
(xix) Zip code 20747 has 1,920 members outside the standard.
(xx) Zip code 20785 has 2,045 members outside the standard.
(xxi) Zip code 20706 has 981 members outside the standard.
(xxii) Zip code 20745 has 1,161 members outside the standard.
(xxiii) Zip code 20746 has 1,278 members outside the standard.
(xxiv) Zip code 20748 has 1,769 members outside the standard.
(xxv) Zip code 21734 has 39 members outside the standard.
(xxvi) Zip code 21746 has 2 members outside the standard.
(xxvii) Zip code 21767 has 55 members outside the standard.

Suburban zip codes:

(i) Zip code 20714 has 364 members outside the standard.
(ii) Zip code 20764 has 273 members outside the standard.
(iii) Zip code 20688 has 136 members outside the standard.
(iv) Zip code 20612 has 22 members outside the standard.
(v) Zip code 20625 has 71 members outside the standard.
(vi) Zip code 20602 has 1,549 members outside the standard.
(vii) Zip code 20603 has 554 members outside the standard.
(viii) Zip code 21664 has 36 members outside the standard.
(ix) Zip code 21714 has 33 members outside the standard.
(x) Zip code 21716 has 435 members outside the standard.
(xi) Zip code 21703 has 2,026 members outside the standard.
(xii) Zip code 20634 has 506 members outside the standard.
(xiii) Zip code 20686 has 21 members outside the standard.

Rural zip codes:

(i) Zip code 20606 has 23 members outside the standard.
(ii) Zip code 20609 has 19 members outside the standard.
(iii) Zip code 20626 has 29 members outside the standard.
(iv) Zip code 20650 has 122 members outside the standard.

C. The Access Plan-Appointment Waiting Time Standards

20. The data submitted by BlueChoice in connection with the BC 2019 Access Plan failed to demonstrate compliance with Appointment Waiting Time Standards.

21. COMAR 31.10.44.05 states, in pertinent part:

> .05 Appointment Waiting Time Standards
>
> A. Sufficiency Standards.
>
> (1) Subject to the exceptions in §B of this regulation, each carrier's provider panel shall meet the waiting time standards listed in §C of this regulation for at least 95 percent of the enrollees covered under health benefit plans that use that provider panel.
>
> (2) When it is clinically appropriate and an enrollee elects to utilize a telehealth appointment, a carrier may consider that utilization as a part of its meeting the standards listed in §C of this regulation.
>
> * * *
>
> C. Chart of Waiting Time Standards

Waiting Time Standards	
Urgent care (including medical, behavioral health, and substance use disorder services)	72 hours
Routine Primary Care	15 Calendar Days
Preventive Visit/Well Visit	30 Calendar Days
Non-Urgent Specialty Care	30 Calendar Days
Non-urgent behavioral health/substance use disorder services	10 Calendar Days

22. The data self-reported by BlueChoice disclosed the following deficiencies:

(a) Routine Primary Care met the required standard of 15 calendar days for 82.93% of enrollees, representing a deficiency of 12.07 percentage points.

(b) Preventive Visit/Well Visit met the required standard of 30 calendar days for 83.58% of enrollees, representing a deficiency of 11.42 percentage points.

(c) Non-Urgent Specialty care met the required standard of 30 calendar days for 79.96% of enrollees, representing a deficiency of 15.04 percentage points.

(d) Non-Urgent Behavioral Health/Substance Use Disorder Services met the required standard of 10 calendar days for 57.53% of enrollees, representing a deficiency of 37.47 percentage points.

23. BlueChoice has acknowledged the deficiencies in its self-reported data regarding Appointment Wait Time Standards, but advised that its wait time standard measurements were based on a proprietary methodology which may have distorted the results by exaggerating the time from the initial request for health care services to the earliest date offered for the appointment for services.

D. <u>The Access Plan-Provider-to-Enrollee Ratio Standards; The Executive Summary</u>

24. COMAR 31.10.44.06 states, in pertinent part:

.06 Provider-to-Enrollee Ratio Standards:

A. Except for a Group Model HMO's health benefit plan, the provider panel for each carrier shall meet the provider-to-enrollee ratio standards listed in §B of this regulation.

B. The provider-to-enrollee ratios shall be equivalent to at least 1 full-time physician, or as appropriate, another full-time provider for:

*   *   *   *

(5) 2,000 enrollees for substance use disorder care or services.

25. COMAR 31.10.44.09 states, in pertinent part:

> .09 Network Adequacy Access Plan Executive Summary Form
>
> A. For each provider panel used by a carrier for a health benefit plan, the carrier shall provide the network sufficiency results for the health benefit plan service area as follows:
>
> *   *   *
>
> (3) Provider-to-Enrollee Ratio Standards
>
> (a) This subsection does not apply to Group Model HMO health benefit plans.
>
> (b) For all other carriers, list whether the percentage of provider-to-enrollee ratios meet the provider-to-enrollee ratio standards listed in Regulation .06[.]

26. The BC 2019 Access Plan failed to include a distinct provider-to-enrollee ratio for substance use disorder care or services.

27. The BC 2019 Access Plan executive summary failed to include a distinct provider-to-enrollee ratio for substance use disorder care or services.

28. BlueChoice has advised that it had aggregated providers for substance use disorder care or services with mental health providers under the ratio for behavioral health care or services, in accordance with the definition of "behavioral health care" in COMAR 31.10.44.02B(2) and was unable to disaggregate providers for substance use disorder care or services in order to report a distinct ratio for those providers for its 2019 data. BlueChoice agreed to include the required ratio in its 2020 Access Plan.

III. CONCLUSIONS OF LAW

29. The Administration concludes that BlueChoice violated § 15-112 of the Insurance Article and COMAR 31.10.44.03C by submitting an access plan that failed to comply with the required travel distance standards and appointment waiting time standards, and by failing to measure and report a required provider-to-enrollee ratio in both the access plan and the executive summary.

30. § 19-729(a) of the Health-General Article states in pertinent part:

> (a) A health maintenance organization may not:
>
> > (1) Violate any provision of this subtitle or any rule or regulation adopted under it[.]

31. § 19-730 of the Health-General Article states in pertinent part:

> (a) If any person violates any provision of § 19-729 of this subtitle, the Administration may:
>
> > (1) Issue an administrative order that requires the health maintenance organization to:
> >
> > > (i) cease inappropriate conduct or practices by it or any of the personnel employed or associated with it;
>
> * * *
>
> > (2) In addition to suspending or revoking a certificate of authority:
> >
> > > (i) impose a penalty of not less than $100, but not more than $125,000 for each violation[.]

ORDER

WHEREFORE, for the reasons set forth above, it is **ORDERED** by the Commissioner and consented to by the Respondent:

A. That the Initial Order is hereby rescinded;

B. That, pursuant to § 19-730 of the Health-General Article, based on consideration of COMAR 31.02.04.02, the Administration imposes an administrative penalty on BlueChoice of $75,000 for the violations of § 15-112 of the Insurance Article and COMAR 31.10.44.03C identified here;

C. The obligation of BlueChoice to pay the aforesaid administrative penalty is hereby suspended pending the Administration's (i) review of the access plan submitted by BlueChoice in 2021; (ii) determination as to whether the 2021 access plan substantiates representations made by BlueChoice related to its intent to adjust record keeping methodologies and to improve its compliance with the Standards; and (iii) based on such review and determination, decision on whether the administrative penalty should be paid, reduced, or rescinded.

OTHER PROVISIONS

D. The executed Order and any administrative penalty shall be sent to the attention of: David Cooney, Associate Commissioner, Life and Health, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202.

E. For the purposes of the Administration and for any subsequent administrative or civil proceedings concerning Respondent, whether related or unrelated to the foregoing paragraphs, and with regard to requests for information about the Respondent made under the Maryland Public Information Act, or properly made by governmental agencies, this Order will be kept and maintained in the regular course of business by the Administration. For the purposes of the business of the Administration, the records and publications of the Administration will reflect this Order.

F. The parties acknowledge that this Order resolves all matters relating to the factual assertions and agreements contained herein and are to be used solely for the

purposes of this proceeding brought by or on behalf of the Administration. Nothing herein shall be deemed a waiver of the Commissioner's right to proceed in an administrative action or civil action for violations not specifically identified in this Order, including, but not limited to, specific consumer complaints received by the Administration, nor shall anything herein be deemed a waiver of the right of the Respondent to contest other proceedings by the Administration. This Order shall not be construed to resolve or preclude any potential or pending civil, administrative, or criminal action or prosecution by any other person, entity or governmental authority, including but not limited to the Insurance Fraud Division of the Administration, regarding any conduct by the Respondent including the conduct that is the subject of this Order.

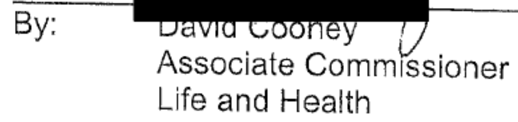
G. Respondent has had the opportunity to have this Order reviewed by legal counsel of its choosing, and is aware of the benefits gained and obligations incurred by the execution of the Order. Respondent waives any and all rights to any hearing or judicial review of this Order to which it would otherwise be entitled under the Insurance Article with respect to any of the determinations made or actions ordered by this Order.

H. This Order contains the entire agreement between the parties relating to the administrative actions addressed herein. This Order supersedes any and all earlier agreements or negotiations, whether oral or written. All time frames set forth in this Order may be amended or modified only by subsequent written agreement of the parties.

I. This Order shall be effective upon signing by the Commissioner or her designee, and is a Final Order of the Commissioner under § 2-204 of the Insurance Article.

J. Failure to comply with the terms of this Order may subject Respondent to further legal and/or administrative action.

Kathleen A. Birrane
INSURANCE COMMISSIONER



By: David Cooney
Associate Commissioner
Life and Health

Date: 5/12/21

RESPONDENT'S CONSENT

RESPONDENT hereby CONSENTS to the representations made in, and to the terms of, the above Consent Order. On behalf of Respondent, the undersigned hereby affirms that he or she has taken all necessary steps to obtain the authority to bind Respondent to the obligations stated herein and does in fact have the authority to bind Respondent to the obligations stated herein.

Name: STACEY R BREIDENSTEIN

Signature: signature on original

Title: VP, Network MGT.

Date: 5/10/21