BEFORE THE MARYLAND INSURANCE ADMINISTRATION

MARYLAND INSURANCE ADMINISTRATION **200 ST. PAUL PLACE, SUITE 2700** **BALTIMORE, MARYLAND 21202** **vs.** **CAREFIRST OF MARYLAND, INC.** **10455 MILL RUN CIRCLE** **OWINGS MILLS, MD 21117** **NAIC# 47058** **GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.** **840 FIRST ST., NE** **WASHINGTON, DC 20065** **NAIC# 53007**	*	**CASE NO:** MIA-2023-03-021

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CONSENT ORDER

This Consent Order is entered into by the Maryland Insurance Commissioner and CAREFIRST OF MARYLAND, INC. ("CFMI") and GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC. ("GHMSI") (collectively "CareFirst" or "Respondent") pursuant to §§ 2-108, 2-204, and 4-113 of the Insurance Article, Maryland Code Annotated, to resolve the matter before the Maryland Insurance Administration ("Administration").

I. RELEVANT REGULATORY FRAMEWORK

1. Each nonprofit health service plan ("NPHSP") 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 NPHSP is required to file a report with the Administration demonstrating the NPHSP's compliance with those standards.

2. Section 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:

* * *

2. a nonprofit health service plan;

(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.

7. 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.

II. FINDINGS

8. CFMI and GHMSI each hold a Certificate of Authority to act as a NPHSP in the State and use provider panels for health benefit plans offered in the State. As such, they are subject to § 15-112 of the Insurance Article and the network adequacy standards set forth in COMAR 31.10.44.04 - .06. In addition, CFMI and GHMSI are required to file a network adequacy plan in accordance with COMAR 31.10.44.03.

9. On July 1, 2021, CareFirst submitted network adequacy plans (the "CareFirst 2021 Access Plans") to the Administration, supplemented with additional

information and documentation on March 31, 2022, May 16, 2022, July 7, 2022, and September 20, 2022.

10. On July 7, 2022, CareFirst requested a temporary waiver from compliance with certain unmet travel distance standards ("the Travel Distance Waiver Request").

11. On September 12, 2022, CareFirst submitted additional information to the Administration supplementing the Travel Distance Waiver Request.

A. The Access Plan-Travel Distance Standards

12. The data submitted by CareFirst in connection with the CareFirst 2021 Access Plans failed to demonstrate compliance with the Travel Distance Standards.

13. 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.
>
> (2) When an enrollee elects to utilize a gynecologist, pediatrician, or certified registered nurse practitioner for primary care, a carrier may consider that utilization as a part of its meeting the primary care provider standards listed in §A(5) of this regulation.

* * *

(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

* * *

Cardiovascular Disease	10	20	60

* * *

Dermatology	10	30	60

* * *

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

* * *

Oncology – Medical and Surgical	10	20	60

* * *

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

Outpatient Infusion/ Chemotherapy	10	30	60

* * *

All other licensed or certified facilities under contract with a carrier not listed	15	40	90

14. The data self-reported by CareFirst 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 99.6% of CFMI suburban enrollees and 99.9% of GHMSI suburban enrollees, leaving 644 CFMI members and 26 GHMSI members outside the travel distance standard of thirty miles in zip code 21842.

(b) Cardiovascular disease providers met the required standard for 99.9% of CFMI urban enrollees, leaving 165 CFMI members outside the travel distance standard of ten miles in two zip codes.

Urban zip codes:

(i) Zip code 21040 has 114 CFMI members outside the standard.
(ii) Zip code 21052 has 51 CFMI members outside the standard.

(c) Dermatology providers met the required standard for 99.9% of CFMI urban enrollees and 99.9% of GHMSI urban enrollees, leaving 51 CFMI members and 1 GHMSI member outside the travel distance standard of ten miles in one zip code in zip code 21052.

(d) Gynecology, OB/GYN providers met the required standard for 99.7% of CFMI urban enrollees and 99.9% of GHMSI urban enrollees, leaving 460 CFMI members and 27 GHMSI members outside the travel distance standard of five miles in three zip codes. The required standard was met for 99.3% of CFMI suburban enrollees and 99.9% of GHMSI suburban enrollees, leaving 1,119 CFMI members and 100 GHMSI members outside the travel distance standard of 10 miles in six zip codes.

Urban zip codes:

(i) Zip code 21403 has 399 CFMI members and 26 GHMSI members outside the standard.
(ii) Zip code 21052 has 51 CFMI members and 1 GHMSI member outside the standard.
(iii) Zip code 21133 has 10 CFMI members outside the standard.

Suburban zip codes:

(i) Zip code 21716 has 512 CFMI members and 48 GHMSI members outside the standard.
(ii) Zip code 20764 has 304 CFMI members and 31 GHMSI members outside the standard.
(iii) Zip code 20625 has 130 CFMI members and 13 GHMSI members outside the standard.
(iv) Zip code 21842 has 101 CFMI members and 5 GHMSI members outside the standard.
(v) Zip code 21913 has 61 CFMI members outside the standard.
(vi) Zip code 20765 has 11 CFMI members and 3 GHMSI members outside the standard.

(e) Gynecology Only providers met the required standard for 99.6% of CFMI suburban enrollees and 99.9% of GHMSI suburban enrollees, leaving 581 CFMI members and 23 GHMSI members outside the

travel distance standard of thirty miles in two zip codes. The required standard was met for 99.2% of CFMI rural enrollees and 99.9% of GHMSI rural enrollees, leaving 1,800 CFMI members and 25 GHMSI members outside the travel distance standard of seventy-five miles in twelve zip codes.

Suburban zip codes:

(i) Zip code 21842 has 491 CFMI members and 21 GHMSI members outside the standard.
(ii) Zip code 20686 has 90 CFMI members and 2 GHMSI members outside the standard.

Rural zip codes:

(i) Zip code 21550 has 651 CFMI members and 10 GHMSI members outside the standard.
(ii) Zip code 21536 has 305 CFMI members and 4 GHMSI members outside the standard.
(iii) Zip code 21561 has 199 CFMI members outside the standard.
(iv) Zip code 21531 has 187 CFMI members and 4 GHMSI members outside the standard.
(v) Zip code 21520 has 169 CFMI members and 3 GHMSI members outside the standard.
(vi) Zip code 21541 has 139 CFMI members and 4 GHMSI members outside the standard.
(vii) Zip code 21532 has 50 CFMI members outside the standard.
(viii) Zip code 21523 has 37 CFMI members outside the standard.
(ix) Zip code 21538 has 28 CFMI members outside the standard.
(x) Zip code 21562 has 18 CFMI members outside the standard.
(xi) Zip code 21562 has 9 CFMI members outside the standard.
(xii) Zip code 21540 has 8 CFMI members outside the standard.

(f) Oncology- Medical/Surgical providers met the required standard for 99.9% of CFMI urban enrollees and 99.9% of GHMSI urban enrollees, leaving 51 CFMI members and 1 GHMSI member outside the travel distance standard of ten miles in zip code 21052.

(g) Acute inpatient hospitals met the required standard for 99.9% of CFMI urban enrollees and 99.9% of GHMSI urban enrollees, leaving 165 CFMI members and 1 GHMSI member outside the travel distance standard of ten miles in two zip codes:

Urban zip codes

(i) Zip code 21040 has 114 CFMI members outside the standard.
(ii) Zip code 21052 has 51 CFMI members and 1 GHMSI member outside the standard.

(h) Critical Care Services – Intensive Care Units met the required standard for 99.9% of CFMI urban enrollees and 99.9% of GHMSI urban enrollees, leaving 165 CFMI members and 1 GHMSI member outside the travel distance standard of ten miles in two zip codes:

Urban zip codes

(i) Zip code 21040 has 114 CFMI members outside the standard.
(ii) Zip code 21052 has 51 CFMI members and 1 GHMSI member outside the standard.

The required standard was met for 99.9% of CFMI suburban enrollees and 99.9% of GHMSI suburban enrollees, leaving 81 CFMI members and 3 GHMSI members outside the travel distance standard of thirty miles in zip code 21664.

(i) Outpatient infusion/chemotherapy facility providers met the required standard for 97.9% of CFMI urban enrollees and 98.4% of GHMSI urban enrollees, leaving 2,822 CFMI members and 1,506 GHMSI

members outside the travel distance standard of ten miles in four zip codes:

Urban zip codes

(i) Zip code 21040 has 1,893 CFMI members and 31 GHMSI members outside the standard.
(ii) Zip code 21052 has 23 CFMI members outside the standard.
(iii) Zip code 21114 has 516 CFMI members and 29 GHMSI members outside the standard.
(iv) Zip code 20904 has 390 CFMI members and 1,446 GHMSI members outside the standard.

(j) All other licensed or certified facilities under contract with the carrier not listed met the required standard for 99.6% of CFMI rural enrollees and 99.9% of GHMSI rural enrollees, leaving 849 CFMI members and 15 GHMSI members outside the travel distance standard of ninety miles in four zip codes:

Rural zip codes

(i) Zip code 21550 has 560 CFMI members and 9 GHMSI members outside the standard.
(ii) Zip code 21531 has 184 CFMI members and 4 GHMSI members outside the standard.
(iii) Zip code 21541 has 97 CFMI members and 2 GHMSI members outside the standard.
(iv) Zip code 21520 has 8 CFMI members outside the standard.

15. With respect to the self-reported deficiencies for Gynecology, OB/GYN and Gynecology Only providers, CareFirst asserts that "[i]f males were eliminated from the calculation, fewer members would fall outside of the distance standard (presumably only half would remain)." Additionally, with respect to the separate provider type of Gynecology, Only, CareFirst contends that "it is entirely reasonable to conclude that

OBGYN providers provide both OB *and* GYN services" and states that "not including OBGYN providers in the GYN travel distance standard leads to misleading results."

16. Regarding the self-reported deficiencies for outpatient infusion/chemotherapy facilities, CareFirst states that "many infusion services are rendered within the regulated space of hospitals. CareFirst maintains 100% of the hospitals in Maryland in its networks and also makes every attempt to contract with outpatient infusion services through professional provider agreements when the centers are part of oncology or other specialty practices."

17. Based on updated information provided to the Administration by the Maryland State Department of Planning and the U.S. Census Bureau, the population density classifications for certain zip codes were changed for the 2022 access plan filings. To match the surrounding zip codes, zip code 21052 was reclassified as suburban and zip code 21664 was reclassified as rural. Additionally, the Administration determined that zip code 21052 is associated with Fort Howard Post Office Boxes and zip code 21664 is associated with Secretary Post Office Boxes. The original population density classifications designated zip code 21052 as urban and zip code 21664 as suburban, due to the large number of Post Office Boxes within a small geographic area. While the 21052 and 21664 zip codes were not officially reclassified as suburban and rural, respectively, for the 2021 access plan filing, the Administration determined that it was appropriate to apply the suburban standards for zip code 21052 and the rural standards for zip code 21664, rather than the urban and suburban standards. Therefore, the Administration has concluded that the CareFirst 2021 Access Plans meet

the travel distance standards for the following provider and facility types in zip codes 21052 and 21664:

(a) With regard to the lack of cardiovascular providers within the regulatory standard of 10 miles for the 51 CFMI members in zip code 21052, CareFirst reports the furthest average distance to a contracted cardiovascular provider is 11.5 miles. The suburban standard is 20 miles.

(b) With regard to the lack of dermatology providers within the regulatory standard of 10 miles in zip code 21052, CareFirst reports the furthest average distance to a contracted dermatology provider is 11.5 miles for the 51 CFMI members and 11.2 miles for the 1 GHMSI member. The suburban standard is 30 miles.

(c) With regard to the lack of Gynecology, OB/GYN providers within the regulatory standard of 5 miles in zip code 21052, CareFirst reports the furthest average distance to a contracted Gynecology, OB/GYN provider is 8 miles for the 51 CFMI members and 7.8 miles for the 1 GHMSI member. The suburban standard is 10 miles.

(d) With regard to the lack of Oncology-Medical/ Surgical providers within the regulatory standard of 10 miles in zip code 21052, CareFirst reports the furthest average distance to a contracted oncology-medical/surgical provider is 11.4 miles for the 51 CFMI members and 11.2 miles for the 1 GHMSI member. The suburban standard is 20 miles.

(e) With regard to the lack of acute inpatient hospitals within the regulatory standard of 10 miles in zip code 21052, CareFirst reports the furthest average distance to a contracted hospital is 13.2 miles for the 51 CFMI members and 13.3 miles for the 1 GHMSI member. The suburban standard is 30 miles.

(f) With regard to the lack of critical care services within the regulatory standard of 10 miles in zip code 21052, CareFirst reports the furthest average distance to a contracted critical care service facility is 11.5 miles for the 51 CFMI members and 11.2 miles for the 1 GHMSI member. The suburban standard is 30 miles.

(g) With regard to the lack of critical care services within the regulatory standard of 30 miles in zip code 21664, CareFirst reports the furthest average distance to a contracted critical care service facility is 49.4 miles for the 81 CFMI members and 49.3 miles for the 3 GHMSI members. The rural standard is 100 miles.

(h) With regard to the lack of outpatient infusion / chemotherapy facilities within the regulatory standard of 10 miles for the 23 CFMI members in zip code 21052, CareFirst reports the furthest average distance to a contracted facility is 12.3 miles. The suburban standard is 30 miles.

B. The Travel Distance Waiver Request

19. The Commissioner finds that CareFirst failed to satisfy the criteria for a waiver set forth in COMAR 31.10.44.07 and its Travel Distance Waiver Request was denied because the Commissioner determined the Travel Distance Waiver Request did not indicate clearly that the providers necessary for an adequate network were unavailable or that CareFirst made an adequate search for additional providers to address the deficiency.

C. The Access Plan-Appointment Waiting Time Standard

20. 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

21. The data self-reported by CareFirst in connection with the CareFirst 2021 Access Plans shows compliance with the Appointment Waiting Time Standards. When asked to provide documentation to support 100% compliance for urgent care, CareFirst responded in pertinent part on May 16, 2022: "We contract with urgent care centers and ensure that our members have adequacy [sic] geoaccess to these specific centers. All urgent care centers are contractually required to provide the following services, as such we meet 100% compliance." CareFirst's response also included a description of contractual requirements it imposes on in-network urgent care centers with respect to the types of services offered and the qualifications of health care providers practicing at urgent care centers.

22. In response to the Administration's requests for additional information related to the urgent care appointment waiting time category, CareFirst provided supplementary information and documentation on June 2, 2022 and August 11, 2022, including urgent care claims data, documentation of the geographic distribution of urgent care centers that participate in the CareFirst network, and further description of the contractual and credentialing requirements CareFirst imposes on in-network urgent care centers with respect to hours of operation and qualifications to provide treatment for mental illness and substance use disorders.

23. The Administration acknowledges that it is reasonable to conclude that urgent care centers can provide urgent care within the required 72-hour waiting time for

most enrollees. For the CareFirst 2021 Access Plans, the Administration has determined that CareFirst provided sufficient justification to demonstrate that at least 95% of urgent care appointments comply with the applicable standard, based on the documentation CareFirst provided with respect to in-network urgent care centers. However, the Administration does not accept CareFirst's contention that inclusion of such centers in the network is a sufficient sole indicator of enrollee waiting time for all services that satisfy the definition of "urgent care" in COMAR 31.10.44.02B(26). In future access plan filings, the Administration expects CareFirst to demonstrate compliance with the appointment waiting time standard for urgent care by supplementing the documentation related to urgent care centers with additional information, such as surveys of a representative sample of in-network providers offering urgent care.

III. CONCLUSIONS OF LAW

24. The Administration concludes that CareFirst violated § 15-112 of the Insurance Article and COMAR 31.10.44.03C by submitting access plans that failed to comply with the required travel distance standards.

25. Section 4-113 of the Insurance Article states in pertinent part:

> (b) The Commissioner may deny a certificate of authority to an applicant or, subject to the hearing provisions of Title 2 of this article, refuse to renew, suspend, or revoke a certificate of authority if the applicant or holder of the certificate of authority:
>
> (1) violates any provision of this article other than one that provides for mandatory denial, refusal to renew, suspension, or revocation for its violation[.]

* * * *

(d) Instead of or in addition to suspending or revoking a certificate of authority, the Commissioner may:

(1) impose on the holder a penalty of not less than $100 but 125,000 for each violation of this article[.]

ORDER

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

A. That, pursuant to § 4-113 of the Insurance Article, based on consideration of COMAR 31.02.04.02, the Administration imposes an administrative penalty on CareFirst of $30,000 for the violations of § 15-112 of the Insurance Article and COMAR 31.10.44.03C identified here.

OTHER PROVISIONS

B. 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.

C. 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.

D. 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.

E. 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.

F. 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.

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

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

Kathleen A. Birrane
INSURANCE COMMISSIONER

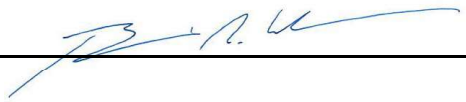
By: David Cooney
Associate Commissioner, Life & Health

Date: March 15, 2023

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: Brian R. Wheeler

Signature: 

Title: VP, Provider Collaboration & Network Transformation

Date: March 13, 2023