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August 19, 2020

TO: David Cooney
Associate Commissioner, Life and Health
Maryland Insurance Administration

FROM: Deborah Rivkin
Vice-President, Government Affairs-Maryland
CareFirst BlueCross Blue Shield

RE: COMAR 31.10.44 Network Adequacy

sent via email to networkadequacy.mia@maryland.gov

Dear Associate Commissioner Cooney:

Thank you for the opportunity to provide comments on COMAR 31.10.44 Network Adequacy, and to participate in continued discussions with the MIA on the best path forward to ensure network adequacy in Maryland. This letter supplements the comments made by CareFirst at the public hearing on August 5.

In general, CareFirst notes that it is critical for carriers to be able to report network adequacy metrics that reflect member access to care that goes beyond the traditional "phone call to an office" to schedule an appointment. These regulations should recognize access to non-traditional modalities and innovative carrier programs when evaluating network adequacy. For example, CareFirst offers its members services to enhance network access including but not limited to a nurse hotline available 24/7, a video visit application, telemedicine coverage for in-network providers, and appointment assistance to members. Such avenues connect our members with providers in innovative ways not pondered by these regulations and not presently accounted for in network adequacy metrics. CareFirst recognizes that not all consumers will have access to certain technology and in those cases we recognize that the offering of such care via certain modalities does not constitute "access"; however, insofar as these modalities and programs are accessible to our members, they contribute to network access and should be counted when assessing carrier compliance with network adequacy.

Comments on Particular Regulations

.04 Travel Distance Standards

CareFirst suggests that the travel distance compliance standard should be reduced from 100% to 90%, consistent with other jurisdictions and CMS. At least six other states and CMS' standards for Medicare Advantage set the compliance standard for travel distance at less than 95%. Six (6) states require a targeted percentage of members (90% unless otherwise designated) whose geographic access must meet the designated services: Nevada, New Hampshire, New Jersey, New Mexico, Pennsylvania, and Washington (80%). CMS requires 90% for travel distance standards for Medicare Advantage.

Additionally, travel standards should take into consideration access to care through telehealth and innovative carrier programs such as those delineated above. While CareFirst has always covered telehealth visits, member utilization of this benefit has greatly increased in the wake of COVID-19. For patients with accessibility to these services for whom telehealth is appropriate, this modality eliminates the very travel distance obstacles that these regulations were designed to combat. It is important that the MIA effectively and fully integrate these options for member access into the travel distance standards of this regulation.

.05 Appointment Waiting Time Standards

(1) UNIFORM METHODOLOGY

It is clear from previous discussions as well as discussions at the August 5 hearing that carriers are measuring appointment waiting time standards in different ways, resulting in inconsistent regulatory application and incomparable results. To ensure that all carriers are subject to the same standard of measurement, CareFirst supports the development of a uniform methodology.

During the August 5 meeting, it was suggested that a "secret shopper" approach to evaluating waiting times may be appropriate. CareFirst cautions against a methodology that determines compliance with wait time standards by employing a "secret shopper" approach—that is, by sampling a certain number of providers and determining how many of those providers on a specific date can provide appointments within the wait time standard and then extrapolating that out to the full network. Beyond the providers called, this calculation does not account for the number of providers within a member's travel distance standard that are available to an enrollee, or the fact that not all enrollees will be asking for appointments on the same date. Further, this method requires that *each provider in the sample* be able to comply with the waiting time standards and is not a measure of whether an enrollee can access at least one provider in their network within the travel distance standards who can provide an appointment within the waiting time window. The "secret shopper" methodology doesn't allow for a network to work the way it is intended—that is, to ensure that a network has enough providers to make sure members have appropriate access even if one specific provider cannot provide timely access. Finally, secret shopper investigations on specific providers and office-based appointments do not capture the full range of access options that health plans offer (e.g., telehealth visits, patient portals, nurse hotlines, and urgent

care clinics). CareFirst strongly believes that the regulation should allow for the full range of member access options to be included in the metric for evaluating provider wait times.

Timely access to health care is an important feature of a high-performing health system. There is, however, very little evidence to inform metrics and appropriate benchmarks for wait time performance. Given the limitations of the literature and experiences in other states with wait time methodologies, we suggest that the MIA work with interested parties in developing uniform metrics, standards, and an evolving methodology for collecting the data needed to monitor timely access to care. We recommend a collaborative stakeholder process that includes the MIA, health plans, providers, and consumers to consider the options, weigh the pros and cons, and make decisions about how to move forward.

(2) TELEHEALTH AND OTHER INNOVATIVE MEMBER SERVICES

If CareFirst provides a clinically appropriate, accessible means of care to its members, such care should be included in evaluating compliance with the waiting time standards. COMAR 31.10.44.05A(2) presently allows a carrier to consider utilization of telehealth to meet its waiting time standards if telehealth is clinically appropriate and an enrollee *elects* [emphasis added] to utilize a telehealth appointment. As discussed above, CareFirst suggests that COMAR 31.10.44.05A(2) be amended to allow a carrier to apply availability of telehealth to its waiting time standard if telehealth is clinically appropriate and accessible to the enrollee, whether the enrollee accepts a telehealth appointment or not, because an appointment was available for the member. As discussed previously, the calculation of waiting times should also contemplate other innovative tools and programs developed by carriers that are accessible to an enrollee to connect the enrollee to care in a timely manner, even if the member chooses not to utilize those tools or programs.

(3) PREVENTATIVE CARE

CareFirst believes that MIA should clarify how sections B and C of this regulation work together. Section B provides that certain preventative care services, follow up care and standing referrals may be scheduled in advance within standards of practice. For example, a member may schedule a child's annual well-visit months in advance. However, in section C's "Chart of Waiting Time Standards" preventative and well visits are included in the list of visits for which an appointment must be available within 30 calendar days after it is requested. It is our understanding from the hearing that the intent of Section B was to exclude appointments that are customarily scheduled well in advance from the 30-day requirement. However, it's not clear from sections B and C working in tandem how the reported waiting time standards distinguish between those preventative visits/well visits that are scheduled in advance and not subject to the 30 day wait time requirement.

.07 Waiver Request Standards

At its public hearing, the MIA asked whether waiver request standards should be mandatory for a carrier that does not meet the requirements in these regulations. Further, the MIA asked whether the current elements for waiver requests in this regulation should be expanded or otherwise changed.

CareFirst has no concerns with the waiver request being mandatory but believes that the waiver request standards should be expanded upon. COMAR 31.10.44.07B provides that the Commissioner may find good cause to grant a 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.

CareFirst suggests adding a fifth criteria for a carrier to demonstrate "good cause" for a waiver request to include past actions taken by the carrier to enhance its network. Section C(5) gives the carrier the opportunity to outline the actions it will take in the future to improve its network, but CareFirst believes that good faith efforts to enhance networks throughout the plan year as demonstrated by detailed actions by the carrier constitutes good cause for granting a waiver.

Additionally, fundamental to the evaluation of a waiver request is a baseline understanding of how many practicing providers exist in the state. In Maryland, as well as nationwide, there are provider shortages in many specialties including obstetrics and gynecology and behavioral health care, particularly in rural areas. CareFirst was supportive of legislation offered last year by Delegate Ariana Kelly to require Health Occupations Boards to publicize a list of licensees to include a number of data points to enable carriers to determine whether a provider is actually practicing and where their office is located. See HB 1616-Health Occupations Boards - Uniform Record-Keeping Requirements. Understanding the universe of providers will help the MIA to evaluate not only a carrier's waiver request, but also a carrier's performance with respect to network adequacy standards, some of which may prove to be mathematically impossible to meet due to provider shortages. This information will also enhance carriers' ability to engage in provider recruitment and outreach for those specialties where adequacy has proved to be challenging.

Thank you, again, for the opportunity to provide feedback on the MIA's network adequacy regulations. We greatly appreciate the MIA's willingness to continue discussions around this issue as we try to improve the process for members, providers and carriers.

Don't hesitate to reach out should you wish to discuss.

Sincerely,

Deborah Rivkin