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March 27, 2023

Ms. Lisa Larson, Director of Hearings
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Dear Ms. Larson:

CareFirst BlueCross BlueShield (CareFirst) appreciates the opportunity to provide formal comments on the Maryland Insurance Administration's (MIA) Draft Proposed Network Adequacy Regulations (COMAR 31.10.44). We offer general feedback on this new proposed regulation for your consideration below, some of which reiterates previous comments we have made and highlighted in the attached for reference. Additionally, we have identified specific issues of concern with this updated regulation and noted in the attached using the comments feature in Word.

CareFirst strongly supports the MIA's policy goal to ensure the services covered in our contracts are readily accessible and available to our members and appreciates the work of the MIA to adopt reasonable network adequacy standards. We continue to express some concerns regarding the proposed data collection requirements, as they are burdensome and not in all cases calibrated to best advance our shared goal. However, we appreciate the MIA's efforts to address several of our previous comments from the draft regulations issued in August 2022 and believe we are closer to a finalized regulation that ensures a meaningful assessment of network adequacy.

CareFirst remains committed to being a good faith partner to the MIA in this effort and remains ready to collaborate in the exploration of alternative policy options, where necessary. We look forward to further discussing these proposed regulations with the MIA in greater detail, and to our active participation in any forthcoming meetings with all stakeholders to advance our shared effort of achieving meaningful regulatory oversight that can be reasonably implemented.

General Comments

(1) Travel Distance Standards

CareFirst reiterates our previous comments regarding the requirement that carriers meet all travel distance standards for 100% of enrollees. We believe that a 100% requirement is not a standard that can be consistently achieved by carriers, and that such a requirement ignores issues such as provider availability, member migration, and data collection and accuracy. The MIA appears to acknowledge this in the waiting time standards, which have been revised downward from a 95% compliance rate to a 90% rate. CareFirst furthermore believes that this standard puts Maryland out of step with other jurisdictions and with other regulatory and credentialing bodies that measure network access, such as NCQA which requires carriers to

have a goal of at least 95% of enrollees live within the maximum travel distance standard and CMS which requires at least 90% of enrollees live within the maximum travel distance standard for qualified health plans on the federal exchange. While we acknowledge and appreciate the potential for a telehealth credit toward meeting travel distance standards, we do not believe that will fully address this issue. CareFirst continues to believe that a non-100% standard is more appropriate for measuring networks, and that the continuation of the 100% standard will necessitate annual waiver requests from carriers meeting very high (>95%) standards, a situation which will place unnecessary and unproductive administrative burdens on both carriers and the Administration. As such, we recommend the MIA modify this requirement such that 95% of enrollees live within the allowed travel distance standards rather than 100%.

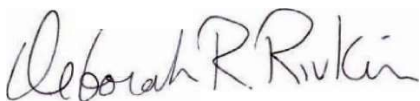
(2) Need to Ensure Travel Distance Standards are Reflective of Provider Practice Patterns

These regulations contain additional new provider types for which carriers must meet specified travel distance standards for urban, suburban and rural areas. For provider types that by nature of their practice only see a subset of our enrollees based on certain demographics (i.e., age or gender), we believe it would be more accurate to only assess travel distance for the members who fall within the universally recognized patient pool. For example, some provider types like obstetrician-gynecologists (OB/GYNs) and psychiatry-adolescent and child outpatient, only see women and children, respectively. Similarly, psychiatry-geriatric would only see older patients. However, carriers are required to satisfy the travel distance standards for all enrollees, even those who would never see a specific provider type because by virtue of their age and/or gender, would not be eligible to be a patient. Including enrollees who are not part of the patient pool for that specific provider type can result in results that do not reflect the actual network accessibility the regulations seek to measure. A better assessment of travel distance would be to calculate the travel distance for each enrollee for only the provider types for which, by virtue of the provider's practice and scope of licensure, they could be a patient. Doing so would provide a more accurate picture of network adequacy and better inform carriers about actual deficiencies in their provider panel.

(3) New Data Requests for Carriers, Providers, and Members

We reiterate our previous comments on the numerous new data requests, not all of which appear in our estimation likely to generate meaningful data regarding whether consumers have adequate access to care. From a staffing, administrative, and financial perspective, the totality of these requirements is more expansive than what exists today and what we see around the country, such as the requirement for quarterly internal compliance audits as part of the *Monitoring Sufficiency Standards*. We believe there are more efficient and meaningful ways for the MIA to gather relevant information and for carriers to demonstrate their ongoing compliance efforts. However, we strongly appreciate the MIA's removal of the enrollee survey used to calculate wait time standards and support the new proposed centralized survey to measure waiting time by carrier.

Sincerely,



Deborah R. Rivkin

Title 31
MARYLAND INSURANCE ADMINISTRATION

Subtitle 10 HEALTH INSURANCE—GENERAL

31.10.44 Network Adequacy

Authority: Insurance Article, §§2-109(a)(1) and 15-112(a)—(d), Annotated Code of Maryland

.02 Definitions.

A. (text unchanged)

B. Terms Defined.

(1) (text unchanged)

(2) *“Ambulatory infusion therapy center” means any location authorized to administer chemotherapy or infusion services on an outpatient basis.*

[(2)] (3) — [(4)] (5) (text unchanged)

(6) *“Continuing care patient” means an individual who, with respect to a provider or facility:*

(a) Is undergoing a course of treatment for a serious and complex condition from the provider or facility;

(b) Is undergoing a course of institutional or inpatient care from the provider or facility;

(c) Is scheduled to undergo nonelective surgery from the provider or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery;

(d) Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

(e) Is or was determined to be terminally ill, as determined under Section 1861(dd)(3)(A) of the Social Security Act, and is receiving treatment for such illness from such provider or facility.

[(5)] (7) *“Enrollee” means a person entitled to health care benefits from a carrier under a policy or contract subject to Maryland law.*

[(6)] (8) *“Essential community provider” means a provider that serves predominantly low-income or medically underserved individuals. “Essential community provider” includes:*

(a) (text unchanged)

(b) Outpatient [behavioral] *mental* health and community based substance use disorder programs;
[and]

(c) Any entity listed in 45 CFR §156.235(c)[.];*and*

(d) *School-based health centers.*

[(7)] (9) — [(12)] (14) (text unchanged)

(15) “*Hospital-based physician*” has the meaning stated in Insurance Article, §14-201, Annotated Code of Maryland.

[(13)] (16) — [(14)] (17) (text unchanged)

[(15)] (18) “Network adequacy waiver [request]” means [a written request from a carrier to the Commissioner wherein the carrier seeks] the Commissioner’s [approval to be relieved] *decision to relieve a carrier of the obligation to comply with* certain network adequacy standards in this chapter for 1 year.

(19) “*On-call physician*” has the meaning stated in Insurance Article, §14-201, Annotated Code of Maryland.

(20) “*Opioid treatment services provider*” means a program with a valid and current accreditation-based license under COMAR 10.63 to provide community-based behavioral health services, and authorized to provide opioid treatment services.

[(16)] (21) — [(17)] (22) (text unchanged)

[(18)] (23) “Primary care [physician] *provider*” means:

(a) A [physician] *provider* who is responsible for:

(i)—(iii) (text unchanged)

(b) “Primary care [physician] *provider*” includes:

(i)—(ii) (text unchanged)

[(19)] (24) — [(20)] (25) (text unchanged)

(26) “*Residential crisis services*” has the meaning stated in Insurance Article, §15-840, Annotated Code of Maryland.

(27) “*Road travel distance*” means:

(a) Actual driving distance measured between two geographic locations based on turn-by-turn directions along public roads; or

(b) Subject to approval by the Commissioner, driving distance between two geographic locations estimated using a methodology that, in the discretion of the Commissioner, sufficiently accounts for significant geographic barriers that are impassable by automobile, such as the Chesapeake Bay.

[(21)] (28) (text unchanged)

(29) “School-based health center” means a community health resource described in Health-General Article, §19-2101, Annotated Code of Maryland that is located within an elementary, middle, or high school and approved by the Maryland Department of Health.

[(22)] (30) — [(23)] (31) (text unchanged)

[(24)] (32) “Telehealth” [means:

(a) As it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a provider to deliver a health care service within the scope of practice of the provider at a location other than the location of the patient.

(b) “Telehealth” does not include:

(i) An audio-only telephone conversation between a provider and a patient;

(ii) An electronic mail message between a provider and a patient; or

(iii) A facsimile transmission between a provider and a patient.] *has the meaning stated in Insurance Article, §15-139, Annotated Code of Maryland.,*

[(25)] (33) — [(26)] (34) (text unchanged)

[(27)] (35) “Waiting time” means the time from the initial request for health care services by an enrollee or by the enrollee’s treating provider to the earliest date offered for the appointment for services with a provider possessing the appropriate skill and expertise to treat the condition.

.03 Network Adequacy Standards.

A. Sufficiency Standards.

(1) A carrier shall develop and maintain a network of providers in sufficient numbers, geographic locations, and practicing specialties to ensure enrollees have access to participating providers for the full scope of benefits and services covered under the carrier’s health benefit plan.

(2) A carrier shall establish written policies and procedures to implement a process for addressing network deficiencies that result in an enrollee lacking access to any providers with the professional training and expertise necessary to deliver a covered service without unreasonable travel or delay.

(3) A carrier shall clearly define and specify referral requirements, if any, to specialty and other providers.

(4) A carrier shall take reasonable steps to ensure that participating providers provide physical access, reasonable accommodations, and accessible equipment for enrollees with physical or mental disabilities.

(5) A carrier's written policies and procedures to monitor availability of services shall include how the carrier will monitor the availability of services for:

(a) Continuing care patients;

(b) Individuals with physical or mental disabilities, including individuals who have disabilities that limit their physical ability to access services; and

(c) Individuals with limited English proficiency, including diverse cultural and ethnic backgrounds.

(6) A carrier shall take reasonable steps to ensure services are delivered in a culturally competent manner to all enrollees, including enrollees:

(a) With limited English proficiency;

(b) With diverse cultural, racial, and ethnic backgrounds; and

(c) Of all genders, sexual orientations, and gender identities.

(7) A carrier must have the ability to identify, by county and for the City of Baltimore, the number of participating providers for each facility type listed in the charts in Regulation .05A(5) and B(5) of this chapter and each provider type code and specialty code listed on the uniform credentialing form described in Insurance Article, §15-112.1, Annotated Code of Maryland.

(8) The identification of the number of participating providers described in §A(7) of this regulation:

(a) Shall include all participating providers who reported a specific provider type or specialty code when completing the uniform credentialing form described in Insurance Article, §15-112.1, Annotated Code of Maryland; and

(b) May include additional participating providers identified by the carrier through other documented means.

(9) *A carrier shall retain copies of its policies and procedures required by this chapter for a period of 3 years following the date the policies and procedures were last effective.*

(10) *At the request of the Commissioner, a carrier shall file with the Commissioner a copy of its current and retained past policies and procedures required by this chapter. A carrier may request a finding by the Commissioner that its policies and procedures are considered confidential commercial information.*

B. Monitoring Sufficiency Standards.

(1) *A carrier shall continuously monitor its provider network for compliance with this chapter and shall conduct internal compliance audits for the standards listed in Regulations .05, .06, and .07 of this chapter on at least a quarterly basis; and*

(2) *A carrier shall continuously verify and update its network directory consistent with Insurance Article, §15-112, Annotated Code of Maryland and §2799A-5 of the Public Health Service Act, enacted by 116 of the federal No Surprises Act.*

[.03] *.04 Filing and Content of Access Plan.*

A. *Using the instructions on the Maryland Insurance Administration's website for submission method and to determine rural, suburban, and urban zip code areas, each carrier subject to this chapter shall file an annual access plan with the Commissioner [through the System for Electronic Rate and Form Filing (SERFF)] on or before July 1 of each year for each provider panel used by the carrier, with the first access plan filing due on or before July 1, 2018.*

B. *(text unchanged)*

C. *Each annual access plan filed with the Commissioner shall include the following information in the standardized format described on the Maryland Insurance Administration's website:*

(1) *An executive summary in the form set forth in Regulation [.09] .11 of this chapter;*

(2) *(text unchanged)*

(3) *A description of out-of-network claims received by the carrier in the prior calendar year, which shall include:*

(a) *The percentage of total claims received that are out-of-network claims;*

(b) *The percentage of out-of-network claims received that are paid;*

(c) *The percentage of claims described in §C(3)(a) and (b) of this regulation that the carrier identifies as claims for emergency services, on-call physicians, or hospital-based physicians;*

(d) *The percentage of total claims received that are out-of-network claims for:*

(i) Subject to §G of this regulation, all enrollees with a residence in a zip code where less than 100 percent of enrollees have access to a provider within the applicable travel distance standard in Regulation .05 of this chapter for the provider type in the claim, listed by provider type for each of the rural, suburban, and urban areas;

(ii) Subject to §G of this regulation, the ten provider types with the highest number of out-of-network claims for enrollees with a residence in each of the rural, suburban, and urban areas, listed by provider type and geographic area; and

(iii) Subject to §G of this regulation, the ten provider types with the highest percentage of total claims that are out-of-network claims for enrollees with a residence in each of the rural, suburban, and urban areas, listed by provider type and geographic area;

(e) For each provider type and geographic area described in §C(3)(d) of this regulation, the following information regarding requests to obtain a referral to an out-of-network provider in accordance with Insurance Article, §15-830, Annotated Code of Maryland:

(i) The number of referral requests received;

(ii) The number of referral requests granted;

(iii) The percentage of out-of-network claims received for which a referral was requested;

(iv) The percentage of out-of-network claims received for which a referral was granted;

(v) The number of single case agreements requested between the carrier and an out-of-network provider;

(vi) The number of single case agreements entered between the carrier and an out-of-network provider;

(vii) The percentage of out-of-network claims received for which a single case agreement was requested between the carrier and an out-of-network provider; and

(viii) The percentage of out-of-network claims received for which a single case agreement was entered between the carrier and an out-of-network provider; and

(f) Any additional information deemed necessary by the carrier to provide context for the information described in §C(3)(a)—(e) of this regulation;

(4) A description of complaints received by the carrier in the prior calendar year relating to access to or availability of providers, which shall include:

(a) The total number of complaints made by enrollees relating to the waiting time or distance of participating providers;

(b) The total number of complaints made by providers, whether or not under contract, relating to the waiting time or distance of participating providers;

(c) The total number of complaints relating to the accuracy of the network directory;

(d) The total number of complaints relating to the dollar amount of reimbursement for out-of-network claims, including balance billing; and

(e) The percentage of complaints described in §C(4)(d) of this regulation that are for claims subject to the federal No Surprises Act;

(5) A description of the carrier's procedures, including training of customer service representatives, detailing how claims will be handled when participating providers are not available and an enrollee obtains health care services pursuant to Insurance Article, §15-830, Annotated Code of Maryland;

(6) A description of the procedures that the carrier will utilize to assist enrollees in obtaining medically necessary services when no participating provider is available without unreasonable travel or delay, including procedures to coordinate care and to limit the likelihood of costs to the enrollee that exceed the amount that would have been incurred had the health care services been provided by a participating provider;

(7) A description of whether the carrier's provider contracts require health care providers to engage in appointment management, including procedures related to:

(a) No show policies;

(b) Patient appointment confirmation;

(c) Same day appointment slotting;

(d) Patient portals;

(e) Access to a provider performance dashboard to monitor appointment lag time, no show rate, bump rate (health care provider initiated cancelation of a scheduled appointment), and new patient appointments; and

(f) Weekly polling programs of providers to check for appointment availability;

(8) An indication of whether the network directory is searchable by covered benefit, for example, hearing aid, knee surgery, or physical therapist;

(9) An indication of whether the carrier has a patient portal for enrollees to make health care appointments;

(10) A description of whether the carrier has a formal process for assisting enrollees who have been unsuccessful in using the network directory to locate an appropriate provider with the necessary skill and expertise to treat the enrollee's condition;

(11) A description of whether and how the carrier considered the role of public transportation in addressing the needs of enrollees who do not own a personal automobile when evaluating enrollees' access to care under the travel distance standards described in Regulation .05 of this chapter;

(12) A description of telehealth utilization as described in Regulation .08 of this chapter;

[(3)] *(13) Documentation justifying to the Commissioner how the access plan meets each network sufficiency standard set forth in Regulations [.04] .05 — [.06] .07 of this chapter; and*

[(4)] *(14) (text unchanged)*

D. The Commissioner may require a carrier to include in the annual access plan a report of the number of participating providers described in Regulation .03A(7) of this chapter for designated facility types, provider type codes, and specialty codes, if the Commissioner notifies the carrier in writing and identifies the particular facility types, provider type codes, and specialty codes that must be reported.

E. The description required by Insurance Article, §15-112(c)(4)(iii), Annotated Code of Maryland shall identify whether the carrier has:

(1) Engaged in outreach to minority health care providers; and

(2) Offered financial incentives, such as payment towards loans previously incurred for health care provider education, to encourage health care providers to contract with the carrier.

F. The description required by Insurance Article, §15-112(c)(4)(iv), Annotated Code of Maryland shall include:

(1) The number of primary care providers who report to the carrier that they use any of the following languages in their practices:

(a) American Sign Language;

(b) Spanish;

(c) Korean;

(d) Chinese (Mandarin or Cantonese);

(e) Tagalog; or

(f) French;

(2) A description of outreach efforts to recruit and retain providers from diverse cultural, racial, or ethnic backgrounds;

(3) A copy of the most recent enrollees' language needs assessment made by or on behalf of the carrier, if one was made;

(4) A copy of the most recent demographic profile of the enrollee population made by or on behalf of the carrier, if one was made;

(5) A copy of any analysis or assessment made of provider network requirements based on an assessment of language needs or demographic profile of the enrollee population;

(6) A copy of any provider manual provisions that describe requirements for access to individuals with physical or mental disabilities; and

(7) Copies of policies and procedures designed to ensure that the provider network is sufficient to address the needs of both adult and child enrollees, including adults and children with:

(a) Limited English proficiency or illiteracy;

(b) Diverse cultural, racial, or ethnic backgrounds;

(c) Physical or mental disabilities; and

(d) Serious, chronic, or complex health conditions.

G. For a group model HMO plan, when an enrollee's place of employment is used instead of residence to calculate travel distance under Regulation .05B of this chapter, the data described in §C(3) of this regulation that is based on enrollee residence shall be reported based on the enrollee's place of employment.

H. The requirements found in §§C(3)—(12) and D—G of this regulation shall apply to annual access plans submitted on or after July 1, 2024.

[.04] .05 Travel Distance Standards.

A. Sufficiency Standards.

(1) Standard and Methodology.

[(1)] *(a) 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] providers, specialty providers, [behavioral] mental 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.

(b) The distances listed in §A(5) of this regulation shall be:

(i) [measured] *Measured from the enrollee's place of residence to the practicing location of the provider or facility[.]; and*

(ii) *Calculated based on road travel distance.*

(c) *Except for those provider types excluded under §A(3) of this regulation, for each provider type and facility type included on the carrier's provider panel, the carrier shall:*

(i) *Map the residences of all Maryland enrollees covered under health benefit plans that use the provider panel;*

(ii) *Calculate the road travel distance for each enrollee to the provider or facility with the closest practicing location;*

(iii) *For each zip code, identify the total number of enrollees residing in the zip code and the number of enrollees residing within an area where the applicable distance standard is not met;*

(iv) *For each zip code, calculate the percentage of enrollees residing within an area where the applicable distance standard is met;*

(v) *For each zip code that includes enrollees for whom the applicable travel distance standard is not met, calculate the average distance to the closest provider or facility for all enrollees residing in the zip code;*

(vi) *For each of the urban, rural, and suburban areas identify the total number of enrollees residing in the geographic area;*

(vii) *For each of the urban, rural, and suburban areas identify the total number of enrollees residing within an area where the applicable distance standard is not met; and*

(viii) *For each of the urban, rural, and suburban areas identify the percentage of enrollees residing within an area where the applicable distance standard is met.*

(d) *Instead of independently calculating the road travel distance for each enrollee as described in §A(1)(c)(i) and (ii) of this regulation, a carrier may use a methodology that:*

(i) *Maps the practicing locations of every participating provider within the geographic area served by the carrier's network or networks;*

(ii) *Identifies any geographic areas within each Maryland zip code that fall outside of the applicable distance standard based on road travel distance from the provider locations; and*

(iii) Enables the carrier to accurately identify the information and perform the calculations described in §A(1)(c)(iii)-(viii) of this regulation.

(e) A carrier shall submit, as part of its documentation justifying to the Commissioner how the access plan meets the network sufficiency standards in this regulation:

(i) Geo-access maps for each provider type and facility type except for those excluded under §A(3) of this regulation showing the practicing locations of participating providers, and identifying either the geographic areas within each zip code where the applicable distance standard is not met, or the locations of enrollees with a residence outside the applicable distance standard;

(ii) For any facility types listed in §A(5) of this regulation that provide services for substance use disorders, the percentage of facilities on the carrier’s provider panel that provide adolescent services; and

(iii) For any facility types listed in §A(5) of this regulation that provide services for substance use disorders, the percentage of facilities on the carrier’s provider panel that provide services for alcohol treatment only, drug abuse treatment only, and alcohol and drug abuse treatment.

(f) A carrier shall report each number and percentage described in §A(1)(c)(iii)—(viii) of this regulation as part of the annual access plan filing.

(2)—(3) (text unchanged)

(4) All other providers and facility types included on the carrier’s provider panel but not listed in the chart in §A(5) of this regulation, including physical therapists and licensed dietitian-nutritionist, shall individually be required to meet maximum distances standards of 15 miles for Urban Areas, 40 miles for Suburban Areas, and 90 miles for Rural Areas.

(5) **Chart** of Travel Distance Standards.

	Urban Area Maximum Distance (miles)	Suburban Area Maximum Distance (miles)	Rural Area Maximum Distance (miles)
Provider Type:			
<i>Addiction Medicine</i>	10	25	60
Allergy and Immunology	15	30	75
Applied Behavioral Analyst	15	30	60
Cardiovascular Disease	10	20	60
Chiropractic	15	30	75
Dermatology	10	30	60
Endocrinology	15	40	90
ENT/Otolaryngology	15	30	75

Gastroenterology	10	30	60
General Surgery	10	20	60
Gynecology, OB/GYN, Nurse-Midwifery/Certified Midwifery	5	10	30
[Gynecology Only	15	30	75]
Licensed Clinical Social Worker	10	25	60
<i>Licensed Professional Counselor</i>	10	25	60
Nephrology	15	25	75
Neurology	10	30	60
Oncology-Medical and Surgical	10	20	60
Oncology-Radiation/Radiation Oncology	15	40	90
Ophthalmology	10	20	60
Pediatrics-Routine/Primary Care	5	10	30
Physiatry, Rehabilitative Medicine	15	30	75
Plastic Surgery	15	40	90
Podiatry	10	30	60
Primary Care [Physician] (<i>non-pediatric</i>)	5	10	30
<i>Psychiatry-Adolescent and Child, Outpatient</i>	10	25	60
<i>Psychiatry-Geriatric, Outpatient</i>	10	25	60
<i>Psychiatry-Outpatient</i>	10	25	60
Psychology	10	25	60
Pulmonology	10	30	60
Rheumatology	15	40	90
Urology	10	30	60
All Other licensed or certified providers under contract with a carrier not listed	15	40	90
Facility Type:			
Acute Inpatient Hospitals	10	30	60
<i>Ambulatory Infusion Therapy Centers</i>	10	30	60
Critical Care Services — Intensive Care Units	10	30	100
Diagnostic Radiology	10	30	60
Inpatient Psychiatric Facility	15	45	75
<i>Opioid Treatment Services Provider</i>	15	25	60
Outpatient Dialysis	10	30	50
[Outpatient Infusion/Chemotherapy	10	30	60]
<i>Outpatient Mental Health Clinic</i>	15	30	60
<i>Outpatient Substance Use Disorder Facility</i>	15	30	60
Pharmacy	5	10	30
<i>Residential Crisis Services</i>	10	30	60
Skilled Nursing Facilities	10	30	60
<i>Substance Use Disorder Residential Treatment Facility</i>	10	25	60
Surgical Services (Outpatient or Ambulatory Surgical Center)	10	30	60
[Other Behavioral Health/Substance Abuse Facilities	10	25	60]

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All other licensed or certified facilities under contract with a carrier not listed	15	40	90
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B. Group Model HMO Plans Sufficiency Standards.

(1) *Standard and Methodology.*

[(1)] (a) Each group model HMO's health benefit plan's provider panel shall have within the geographic area served by the group model HMO's network or networks, sufficient primary care [physicians] *providers*, specialty providers, [behavioral] *mental* health and substance use disorder providers, hospitals, and health care facilities to meet the maximum travel distance standards listed in the chart in §B(5) of this regulation for each type geographic area.

(b) The distances listed in §B(5) of this regulation shall be:

(i)[measured] *Measured* from the enrollee's place of residence or, *at the option of the carrier*, place of employment from which the enrollee gains eligibility for participation in the group model HMO's health benefit plan *to the practicing location of the provider or facility*[.]; and

(ii) *Calculated based on road travel distance.*

(c) *Except for those provider types excluded §B(3) of this regulation, for each provider type and facility type included on the group model HMO's provider panel, the carrier shall:*

(i) *Map the residences or places of employment of all Maryland enrollees covered under health benefit plans that use the provider panel;*

(ii) *Calculate the road travel distance for each enrollee to the provider or facility with the closest practicing location;*

(iii) *For each zip code identify the total number of enrollees with a residence or place of employment in the zip code and the number of enrollees with a residence or a place of employment within an area where the applicable distance standard is not met;*

(iv) *For each zip code calculate the percentage of enrollees with a residence or place of employment within an area where the applicable distance standard is met;*

(v) *For each zip code that includes enrollees for whom the applicable travel distance standard is not met, calculate the average distance to the closest provider or facility for all enrollees with a residence or place of employment within the zip code;*

(vi) *For each of the urban, rural, and suburban areas identify the total number of enrollees with a residence or place of employment in the geographic area;*

(vii) For each of the urban, rural, and suburban areas identify the number of enrollees with a residence or place of employment within an area where the applicable distance standard is not met; and

(viii) For each of the urban, rural, and suburban areas identify the percentage of enrollees with a residence or place of employment within an area where the applicable distance standard is met.

(d) Instead of independently calculating the road travel distance for each enrollee as described in §B(1)(c)(i) and (ii) of this regulation, a carrier may use a methodology that:

(i) Maps the practicing locations of every participating provider within the geographic area served by the group model HMO's network or networks;

(ii) Identifies any geographic areas within each Maryland zip code that fall outside of the applicable distance standard based on road travel distance from the provider locations; and

(iii) Enables the carrier to accurately identify the information and perform the calculations described in §B(1)(c)(iii)—(viii) of this regulation.

(e) When calculating the number or percentage of enrollees with a place of employment within an area or zip code under §B(1)(c)(iii)—(viii) of this regulation, the carrier shall include only those enrollees who gain eligibility for participation in the group model HMO's health benefit plan from their place of employment.

(f) A carrier shall submit, as part of its documentation justifying to the Commissioner how the access plan meets the network sufficiency standards in this regulation:

(i) Geo-access maps for each provider type and facility type except for those excluded under §B(3) of this regulation showing the practicing locations of participating providers, and identifying either the geographic areas within each zip code where the applicable distance standard is not met, or the locations of enrollees with a residence or place of employment outside the applicable distance standard;

(ii) For any facility types listed in §B(5) of this regulation that provide services for substance use disorders, the percentage of facilities on the carrier's provider panel that provide adolescent services; and

(iii) For any facility types listed in §B(5) of this regulation that provide services for substance use disorders, the percentage of facilities on the carrier's provider panel that provide services for alcohol treatment only, drug abuse treatment only, and alcohol and drug abuse treatment.

(g) A carrier shall report each number and percentage described in §B(1)(c)(iii)—(viii) of this regulation as part of the annual access plan filing.

(2)—(3) (text unchanged)

(4) All other provider and facility types *included on the carrier's provider panel, but not listed in the chart at §B(5) of this regulation, including physical therapists and licensed dietitian-nutritionist*, shall individually be required to meet maximum distances standards of [15] 20 miles for Urban Areas, 40 miles for Suburban Areas, and 90 miles for Rural Areas.

(5) Chart of Travel Distance Standards.

	Urban Area Maximum Distance (miles)	Suburban Area Maximum Distance (miles)	Rural Area Maximum Distance (miles)
Provider Type:			
<i>Addiction Medicine</i>	15	30	75
Allergy and Immunology	20	30	75
Applied Behavioral Analyst	15	20	60
Cardiovascular Disease	15	25	60
Chiropractic	20	30	75
Dermatology	20	30	60
Endocrinology	20	40	90
ENT/Otolaryngology	20	30	75
Gastroenterology	20	30	60
General Surgery	20	30	60
Gynecology, OB/GYN, <i>Nurse-Midwifery/Certified Midwifery</i>	15	20	45
[Gynecology Only	15	30	60]
Licensed Clinical Social Worker	15	30	75
<i>Licensed Professional Counselor</i>	15	30	75
Nephrology	15	30	75
Neurology	15	30	60
Oncology-Medical, Surgical	15	30	60
Oncology-Radiation/Radiation Oncology	15	40	90
Ophthalmology	15	20	60
Pediatrics-Routine/Primary Care	15	20	45

Physiatry, Rehabilitative Medicine	15	30	75
Plastic Surgery	15	40	90
Podiatry	15	30	90
Primary Care [Physician] (<i>non-pediatric</i>)	15	20	45
<i>Psychiatry-Adolescent and Child, Outpatient</i>	15	30	60
<i>Psychiatry-Geriatric, Outpatient</i>	15	30	60
<i>Psychiatry-Outpatient</i>	15	30	60
Psychology	15	30	60
Pulmonology	15	30	60
Rheumatology	15	40	90
Urology	15	30	60
All Other licensed or certified providers under contract with a carrier not listed	20	40	90
Facility Type:			
Acute Inpatient Hospitals	15	30	60
<i>Ambulatory Infusion Therapy Center</i>	15	30	60
Critical Care Services-Intensive Care Units	15	30	120
Diagnostic Radiology	15	30	60
Inpatient Psychiatric Facility	15	45	75
<i>Opioid Treatment Services Provider</i>	15	30	60
Outpatient Dialysis	15	30	60
[Outpatient Infusion/Chemotherapy	15	30	60]
<i>Outpatient Mental Health Clinic</i>	15	30	60
<i>Outpatient Substance Use Disorder Facility</i>	15	30	60
Pharmacy	5	10	30
<i>Residential Crisis Services</i>	15	30	60
Skilled Nursing Facilities	15	30	60
<i>Substance Use Disorder Residential Treatment Facility</i>	15	30	60

Surgical Services (Outpatient or Ambulatory Surgical Center)	10	30	60
[Other Behavioral Health/Substance Abuse Facilities	15	30	60]
All other licensed or certified facilities under contract with a carrier not listed	15	40	120

C. Essential Community Providers.

(1) Each provider panel of a carrier, that is not a group model HMO provider panel, shall include:

~~(a)~~ **(a)** At least 30 percent of the available essential community providers *providing medical services* in each of the urban, rural, and suburban areas[.];

(b) At least 30 percent of the available essential community providers providing mental health services in each of the urban, rural, and suburban areas; and

(c) At least 30 percent of the available essential community providers providing substance use disorder services in each of the urban, rural, and suburban areas.

(2) *Methodology for calculating essential community provider inclusion standard.*

(a) Except as provided in §§C(2)(b) and (c) of this regulation, a carrier shall use the MHBE ECP Network Inclusion Calculation Methodology that is described in the Instructions on Meeting the Essential Community Provider Plan Certification Standard guidance provided by the Maryland Health Benefit Exchange, which is current as of the date 3 months prior to the due date of the annual access plan.

(b) The calculation described in §C(2)(a) of this regulation shall be performed separately for essential community providers providing medical services, mental health services, and substance use disorder services in each of the urban, rural, and suburban areas.

(c) If the Maryland Health Benefit Exchange changes the MHBE ECP Network Inclusion Calculation Methodology after the effective date of this regulation, a carrier may not use the revised methodology to calculate the essential community provider inclusion standard in §C(1) of this regulation unless the Commissioner has approved the revised methodology for this purpose.

[(2)] (3)—[(3)] (4) (text unchanged)

[.05] .06 Appointment Waiting Time Standards.

A. Network Capacity.

(1) Each carrier shall create and utilize written policies and procedures to monitor the availability of services.

(2) On a semiannual basis, each carrier shall make available to its enrollees the median waiting times to obtain the following in-person appointments with a participating provider as measured from the date of the initial request to the date of the earliest available in-person appointment:

(a) Urgent care for medical services;

(b) Inpatient urgent care for mental health services;

(c) Inpatient urgent care for substance use disorder services;

(d) Outpatient urgent care for mental health services;

(e) Outpatient urgent care for substance use disorder services;

(f) Routine primary care;

(g) Preventive care/well visits;

(h) Non-urgent specialty care;

(i) Non-urgent mental health care; and

(j) Non-urgent substance use disorder care.

(3) To calculate the median waiting times for the appointments described in §A(2) of this regulation, a carrier shall:

(a) Make direct contact with a random selection of provider offices qualified to provide the services for each of the appointment types listed in §A(2) of this regulation to ask for next available in-person appointments; and

(b) Retain documentation of the efforts described in §A(3)(a) of this regulation.

(4) The minimum sample size for the random selection of provider offices described in §A(3)(a) of this regulation shall be equivalent to the lesser of:

(a) Fifty percent of the participating providers qualified to provide the services for each of the appointment types listed in §A(2) of this regulation; or

(b) One hundred provider offices.

(5) The Commissioner may conduct a centralized survey to measure waiting time, by carrier, for each appointment type listed in §A(2) of this regulation.

(a) The survey described in §A(5) of this regulation shall utilize a statistically reliable and valid methodology that includes making direct contact with a random selection of participating providers for each carrier who are qualified to provide the services for each of the appointment types listed in §A(2) of this regulation to ask for next available appointments.

(b) The Commissioner may:

(i) Contract with a vendor to conduct the survey; and

(ii) Charge a carrier a reasonable fee to cover the costs of the survey.

(c) The Commissioner shall publish the methodology used to conduct the survey on the Maryland Insurance Administration's website.

(d) For any semiannual period in which the Commissioner conducts the survey described in §A(5) of this regulation:

(i) The Commissioner shall provide notice to each carrier subject to this chapter of the intent to conduct the survey at least 3 months in advance;

(ii) The Commissioner may require each carrier to submit a current roster of network providers for each provider panel used by the carrier, and any additional information the Commissioner determines is necessary for the survey to be conducted; and

(iii) A carrier is exempt from the requirement to make direct contact with a random selection of provider offices to calculate the median waiting times as described in §A(3) of this regulation.

[A.] B. Sufficiency Standards.

(1) On a semiannual basis, a carrier shall determine whether the provider panel meets the waiting time standards listed in §E of this regulation based on the direct contacts with provider offices described in §A(3)(a) of this regulation or the survey described in §A(5) of this regulation.

[(1)] (2) Subject to the exceptions in **[(§B)] §§C and D** of this regulation, **[each carrier's provider panel shall meet the waiting time standards listed in §E of this regulation for at least 95 percent of the enrollees covered under health benefit plans that use that provider panel]** *if a carrier's provider panel fails to meet the waiting time standards listed in §E of this regulation for at least 90 percent of appointments in each category, the carrier shall notify the Administration within 10 business days identifying the deficiency in the provider network and the efforts that have been taken or will be taken to correct the deficiency.*

[(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.]

[B.] C. Preventive care services and periodic follow-up care, including but not limited to, standing referrals to specialty providers for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or [behavioral] *mental* health or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating provider acting within the scope of the provider’s license, certification, or other authorization.

D. A visit scheduled in advance in accordance with §C of this regulation may be disregarded when determining compliance with the waiting time standards listed in §E of this regulation.

[C.] E. Chart of Waiting Time Standards.

Waiting Time Standards	
Urgent care <i>for medical services</i> [(including] medical, behavioral health, and substance use disorder services)]	72 hours
<i>Inpatient urgent care for mental health services</i>	72 hours
<i>Inpatient urgent care for substance use disorder services</i>	72 hours
<i>Outpatient urgent care for mental health services</i>	72 hours
<i>Outpatient urgent care for substance use disorder services</i>	72 hours
Routine primary care	15 calendar days
Preventive [visit] <i>care/well visit</i>	30 calendar days
Non-urgent specialty care	30 calendar days
<i>Non-urgent mental health care</i>	10 calendar days
Non-urgent [behavioral health/] substance use disorder [services] <i>care</i>	10 calendar days

[.06] .07 Provider-to-Enrollee Ratio Standards.

A. (text unchanged)

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

(1)—(3) (text unchanged)

(4) 2,000 enrollees for [behavioral] *mental* health care or services; and

(5) (text unchanged)

C. The ratios described in §B of this regulation shall be calculated based on:

(1) The number of enrollees covered under all health benefit plans issued by the carrier in Maryland that use that provider panel; and

(2) The number of providers in that provider panel with practicing locations:

(a) In Maryland; or

(b) Within the applicable maximum travel distance standard specified in Regulation .05 of this chapter outside the geographic boundaries of Maryland.

.08 Telehealth.

A. Telehealth Utilization Data Reporting.

(1) For annual access plans submitted on or after July 1, 2024, a carrier shall report the following data on telehealth utilization for the calendar year prior to submission of the annual access plan:

(a) The total number of in-network telehealth claims for each provider type and facility type listed in Regulation .05 of this chapter in each of the urban, rural, and suburban areas and in each Maryland county and Baltimore City; and

(b) The percentage of total in-network claims for each provider type and facility type listed in Regulation .05 of this chapter in each of the urban, rural, and suburban areas and in each Maryland county and Baltimore City that are in-network telehealth claims.

(2) The geographic area for claims data described in §A(1) of this regulation shall be based on:

(a) The enrollee's place of residence; or

(b) When an enrollee's place of employment is used instead of residence to calculate travel distance under Regulation .05B of this chapter for a group model HMO, place of employment from which the enrollee gains eligibility for participation in the health benefit plan.

B. Travel Distance Credit.

(1) Subject to approval by the Commissioner as described in §B(5) of this regulation, when calculating the enrollee travel distance for each provider type under Regulation .05A and B of this chapter, a carrier may apply a per-enrollee telehealth mileage credit in a geographic area where

the applicable maximum travel distance standard is not met as measured between the practicing location of the nearest provider and the enrollee's place of residence or, at the option of a group model HMO, place of employment from which the enrollee gains eligibility for participation in the health benefit plan.

(2) The telehealth mileage credit described in §B(1) of this regulation shall be:

(a) Five miles for an enrollee with a residence or, for a group model HMO, place of employment from which the enrollee gains eligibility for participation in the health benefit plan, in an urban geographic area;

(b) Ten miles for an enrollee with a residence or, for a group model HMO, place of employment from which the enrollee gains eligibility for participation in the health benefit plan, in a suburban geographic area; and

(c) Fifteen miles for an enrollee with a residence or, for a group model HMO, place of employment from which the enrollee gains eligibility for participation in the health benefit plan, in a rural geographic area.

(3) The telehealth mileage credit described in §B(1) of this regulation may be applied to a maximum of 10 percent of enrollees for each provider type in each of the urban, rural, or suburban geographic areas.

(4) A carrier seeking to apply the telehealth mileage credit described in §B(1) of this regulation shall identify:

(a) Each provider type and geographic area to which the credit is being applied;

(b) The percentage of enrollees for which the carrier met the travel distance standard for the provider type and geographic area before the credit was applied; and

(c) The percentage of enrollees for which the carrier met the travel distance standard for the provider type and geographic area after the credit was applied.

(5) The Commissioner may approve the telehealth mileage credit described in §B(1) of this regulation if the carrier sufficiently demonstrates that it provides coverage for and access to clinically appropriate telehealth services from participating providers for the provider type and geographic area to which the credit is being applied, in accordance with the documentation requirements of §D of this regulation.

C. Appointment Waiting Time Credit.

(1) Subject to approval by the Commissioner as described in §C(3) of this regulation, when determining whether the carrier's provider panel meets the waiting time standards under Regulation .06E of this chapter for at least 90 percent of appointments in each category, a carrier

may apply a telehealth credit of up to 10 percent for each appointment category where the standard is not met.

(2) A carrier seeking to apply the telehealth credit described in §C(1) of this regulation shall identify:

(a) Each appointment type to which the credit is being applied;

(b) The percentage of appointments for which the carrier met the waiting time standard before the credit was applied; and

(c) The percentage of appointments for which the carrier met the waiting time standard after the credit was applied.

(3) The Commissioner may approve the telehealth credit described in §C(1) of this regulation if a carrier sufficiently demonstrates, in accordance with the documentation requirements of §D of this regulation, that:

(a) The carrier provides coverage for and access to clinically appropriate telehealth services from participating providers for the appointment type to which the credit is being applied;

(b) The carrier provides coverage for a corresponding in-person service if the enrollee chooses not to elect utilization of a telehealth service; and

(c) The carrier establishes, maintains, and adheres to written policies and procedures to assist enrollees for whom a telehealth service is not clinically appropriate, not available, or not accessible with obtaining timely access to an in-person appointment within a reasonable travel distance with:

(i) A participating provider; or

(ii) A nonparticipating provider at no greater cost to the enrollee than if the service was obtained from a participating provider.

D. Required Documentation.

(1) A carrier seeking to apply the telehealth credit described in §B(1) or C(1) of the regulation shall submit the following documentation to demonstrate that it provides coverage for and access to clinically appropriate telehealth services as described in §§B(5) and C(3)(a) of this regulation:

(a) A description of any requirements imposed or incentives provided for participating providers to offer telehealth services;

(b) A detailed description of all telehealth services offered under the health benefit plans issued by the carrier in Maryland that use the provider panel including:

(i) Telehealth modalities covered;

(ii) Types of platforms through which participating providers may deliver telehealth;

(iii) Whether the carrier offers or provides services through a telehealth-only vendor or platform, and which types of services are provided on this basis;

(iv) Whether the carrier arranges for telehealth services to be available on a 24/7 basis, and which types of services are provided on this basis;

(v) Whether the carrier arranges for telehealth kiosks to be installed and maintained in convenient locations throughout Maryland; and

(vi) The specific services available through telehealth for each provider type and appointment type to which the telehealth credit is being applied;

(c) Evidence that telehealth is clinically appropriate and available for the services performed by each provider type and for each appointment type to which the telehealth credit is being applied, which may include:

(i) Actual telehealth utilization data comparing telehealth claims for the specific provider type or appointment type to telehealth claims for all provider types or appointment types;

(ii) Actual telehealth utilization data comparing telehealth claims for the specific provider type or appointment type to all claims for the same provider type or appointment type;

(iii) Survey results or attestations from participating providers indicating that telehealth is offered for the services performed by the specific provider type or for the specific appointment type;

(iv) Enrollee survey results indicating that enrollees have the willingness and ability to use telehealth services for the specific provider type or appointment type; and

(v) Other documentation that, in the discretion of the Commissioner, demonstrates the clinical appropriateness and availability of telehealth services for the provider type or appointment type to which the credit is being applied; and

(d) For the telehealth mileage credit described in §B(1) of this regulation, evidence that telehealth services in general are available and accessible in the zip codes where the telehealth mileage credit is being applied to enrollee's residence or place of employment, which may include:

(i) Actual telehealth utilization data comparing the ratio of telehealth claims to in-person claims for all types of services on the aggregate in the geographic area of the zip codes where the credit is being applied to the ratio of telehealth claims to in-person claims for all types of services on the aggregate statewide;

(ii) Enrollee survey results indicating that enrollees have the willingness and ability to use telehealth services in general in the geographic area where the credit is being applied; and

(iii) Other documentation that, in the discretion of the Commissioner, demonstrates the availability and accessibility of telehealth services in the zip codes where the credit is being applied.

(2) A carrier seeking to apply the telehealth credit described in §C(1) of the regulation shall submit the following documentation to demonstrate that it provides coverage for a corresponding in-person service and that it establishes, maintains, and adheres to written policies and procedures to assist enrollees with obtaining timely access to an in-person appointment as described in §C(3)(b)—(c) of this regulation:

(a) Excerpts from actual plan materials describing benefits for telehealth and in-person services;

(b) Copies of the actual written policies and procedures;

(c) A description of any information, outreach, and educational materials the carrier provides to enrollees informing them of the assistance available from the carrier to assist with obtaining a timely appointment;

(d) A description of whether the carrier provides assistance on a 24/7 basis to guide enrollees needing urgent care after normal business hours to an appropriate provider, including assistance provided through a customer service telephone option or a contracted telehealth triage service; and

(e) Evidence that the carrier ensures, in practice, that enrollees are able to obtain timely access to an in-person appointment as described in §C(3)(c) of this regulation, which may include:

(i) Documentation of the number of enrollees the carrier assisted with getting appointments within the applicable waiting time standard under Regulation .06E of this chapter;

(ii) Documentation of the number of appointments with a nonparticipating provider for the appointment type to which the credit is being applied where the enrollee received services at no greater cost than if the service was obtained from a participating provider;

(iii) Enrollee survey results indicating satisfaction with the carrier's efforts to provide assistance with obtaining a timely in-person appointment; and

(iv) Other documentation that, in the discretion of the Commissioner, demonstrates that the carrier regularly assists enrollees in obtaining timely in-person appointments.

[.07] .09 Network Adequacy 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.] *If a carrier's provider panel fails to meet one or more of the standards specified in Regulations .05—.07 of this chapter, the carrier shall provide the following information to the Commissioner as part of the annual access plan:*

(1) A description of any network adequacy waiver previously granted by the Commissioner;

(2) An explanation of how many providers in each specialty or health care facility type that the carrier reasonably estimates it would need to contract with or otherwise include in its network to satisfy each unmet standard;

(3) A description of the methodology used to calculate the estimated number of providers in §A(2) of this regulation;

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

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

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

(7) An analysis of any trends in the reasons given by physicians, providers, or health care facilities for refusing to contract with the carrier, and a description of the carrier's proposals or attempts to address those reasons and improve future contracting efforts;

(8) Identification of all incentives the carrier offers to providers to join the network;

(9) If applicable, a substantiated statement that there are insufficient numbers of physicians, other providers, or health care facilities available within the relevant service area for a covered service or services for which the carrier failed to meet a standard;

(10) A description of other efforts and initiatives undertaken by the carrier in the past year to enhance its network and address the deficiencies that contributed to each unmet standard;

(11) A description of steps the carrier will take to attempt to improve its network to avoid a future failure to meet a standard;

(12) An explanation of any other mitigating factors that the carrier requests the Commissioner to consider; and

(13) An attestation to the accuracy of the information provided in relation to each unmet standard.

B. The Commissioner may find good cause to grant [the] a network adequacy waiver [request] of one or more of the standards specified in Regulations .05—.07 of this chapter, if the information provided by the carrier under §A of this regulation demonstrates that:

(1) [the] The physicians, other providers, or health care facilities necessary for an adequate network:

[(1)] (a)—[(3)] (c) (text unchanged)

[(4)] (d) Are unable to reach agreement with the carrier; or

(2) The reported failure to meet a standard is a result of limitations or constraints with the measurement methodology rather than an actual deficiency in the network.

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

(1) A description of any waiver previously granted by the Commissioner;

(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;

(6) If applicable, a statement that there are no physicians, other providers, or health care facilities available within the relevant service area for a covered service or services for which the carrier requests the waiver; and

(7) An attestation to the accuracy of the information contained in the network adequacy waiver request.] *The Commissioner shall post a list of all network adequacy waivers that are granted for each annual access plan on the Maryland Insurance Administration's website.*

[.08] .10 Confidential Information in Access Plans.

A. Subject to [§15-802 of the] Insurance Article, §15-802, Annotated Code of Maryland, the following information that is included in a carrier's access plan shall be considered confidential by the Commissioner:

(1) [Methodology] *Proprietary methodology* used to annually assess the carrier’s performance in meeting the standards established under this chapter;

(2) [Methodology] *Proprietary methodology* used to annually measure timely access to health care services; and

(3) (text unchanged)

B. A carrier submitting an access plan or [a] *supplemental information required for the network adequacy waiver* [request] *standards* may submit a written request to the Commissioner that specific information included in the plan [or request] not be disclosed under the Public Information Act and shall:

(1)—(2) (text unchanged)

C.—D. (text unchanged)

[.09] .11 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 following network sufficiency results for the health benefit plan service area [as follows] *in the standardized format described on the Maryland Insurance Administration’s website:*

(1) Travel Distance Standards.

(a) For each provider type *and facility type* listed in Regulation [.04] .05 of this chapter, list the percentage of enrollees for which the carrier met the travel distance standards, in the following format, *with provider types listed first in alphabetical order, followed by facility types in alphabetical order:*

	Urban Area	Suburban Area	Rural Area
[Primary Care Provider] <i>Provider Type</i>			
[Specialty Provider] <i>Facility Type</i>			

(b) *All provider and facility types described in §§A(4) and B(4) of Regulation .05 of this chapter and included on the carrier’s provider panel shall be listed individually in the chart described in §A(1)(a) of this regulation with the corresponding data for that specific type of provider or facility.*

(c) If the telehealth mileage credit described Regulation .08B of this chapter was applied when calculating the percentage of enrollees for which the carrier met the travel distance standards, the carrier shall:

(i) Note the particular provider types and geographic areas to which the credit was applied by including an asterisk in the chart; and

(ii) Include a corresponding footnote stating “As permitted by Maryland regulations, a telehealth mileage credit was applied to up to 10 percent of enrollees for each provider type noted with an asterisk in each of the urban, rural, or suburban geographic areas. The mileage credit is 5 miles for urban areas, 10 miles for suburban areas, and 15 miles for rural areas.”

[(b)] (d)— [(c)] (e) (text unchanged)

[(d)] (f) List the total number of essential community providers in the carrier’s network in each of the urban, rural, and suburban areas providing:

(i) Medical services;

(ii) Mental health services; and

(iii) Substance use disorder services.

[(e)] (g) List the total percentage of essential community providers available in the health benefit plan’s service area that are participating providers for each of the nine categories described in §A(1)(f) of this regulation.

[(f)] List the total number and percentage of local health departments in the carrier’s network providing:

(i) Medical services;

(ii) Mental health services; and

(iii) Substance use disorder services.

(2) Appointment Waiting Time Standards.

(a) For each appointment type listed in Regulation [.05] .06 of this chapter, list the [percentage of enrollees for which the carrier met the appointment wait time standards] calculated median waiting time to obtain an in-person appointment with a participating provider, in the following format:

Appointment Waiting Time Standard Results	
Urgent care for medical services [— within 72 hours]	

<i>Inpatient urgent care for mental health services</i>	
<i>Inpatient urgent care for substance use disorder services</i>	
<i>Outpatient urgent care for mental health services</i>	
<i>Outpatient urgent care for substance use disorder services</i>	
Routine primary care [— within 15 calendar days]	
[Preventative Visit] <i>Preventive care/Well Visit</i> — within 30 calendar days]	
Non-urgent specialty care [— within 30 calendar days]	
[Non-urgent ancillary services — within 30 calendar days]	
Non-urgent [behavioral] <i>mental health</i> /substance use disorder services — within 10 calendar days] <i>care</i>	
<i>Non-urgent substance use disorder care</i>	

(b) [List the total percentage of telehealth appointments counted as part of the appointment waiting time standard results]. *If the telehealth credit described Regulation .08C of this chapter was applied when determining whether the carrier’s provider panel met the waiting time standards under Regulation .06E of this chapter for at least 90 percent of appointments in any category, the carrier may include a statement on the executive summary disclosing the availability of telehealth appointments to supplement the in-person appointments for that category.*

(c) *If the carrier arranges for telehealth services to be provided from participating providers beyond traditional office hours for an appointment type listed in Regulation .06 of this chapter, the carrier may include a statement on the executive summary disclosing the availability of those services.*

(3) Provider-to-Enrollee Ratio Standards.

(a) (text unchanged)

(b) For all other carriers, [list whether the percentage of provider-to-enrollee ratios meet the] *summarize the network performance for each provider-to-enrollee ratio [standards] standard listed in Regulation [.06] .07 of this chapter by listing the calculated number of providers in the provider panel, rounded to the nearest whole number, for each of the following categories of enrollees:*

(i)—(iii) (text unchanged)

(iv) 2,000 enrollees for [behavioral] *mental health care or service; and*

(v) (text unchanged)

B. (text unchanged)

KATHLEEN A. BIRRANE
Insurance Commissioner