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August 8, 2022

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

***Sent via email*: networkadequacy.mia@maryland.gov**

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 for your consideration below and have attached specific substantive issues of concern with proposed alternatives using the comments feature in Word. Additionally, we have suggested some edits to address minor technical issues in the regulation using tracked changes.

CareFirst supports the MIA's policy goal to ensure the services covered in our contracts are readily accessible and available to our members; however, we continue to have concerns regarding the proposed data collection requirements, as they are burdensome and not in all cases calibrated to best advance our shared goal of advancing network adequacy. We appreciate the addition of the proposed telehealth credit but have some questions regarding how it will be operationalized.

CareFirst remains committed to being a good faith partner to the MIA in this effort and is prepared to collaborate in the exploration of alternative policy options, where necessary, to ensure the use of meaningful measures of network adequacy. 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) Need for Clear Language and Synergy with Existing Statutes

In our detailed comments attached, you will note there are multiple requests seeking clarification on proposed language. In some instances, the MIA uses broad language that makes it difficult for carriers to ascertain the true meaning and intent. For example, § .03(B)(1) requires that carriers "shall conduct internal compliance audits…" regarding network adequacy, but it is not clear how this internal compliance audit differs from the geo-access maps required in § .05(A). Additionally, the proposed new provisions in § .04(C)(3) include numerous data elements, and the relation of some of these data requirements to adequacy measurements is unclear, as they appear to be neither a direct determination nor a predictor of network adequacy. CareFirst offers some suggestions to limit the scope of this section to only include meaningful data which can be reasonably obtained. Additionally, we reiterate the need for requirements regarding essential community providers (ECPs) as referenced in § .05(C) to be consistent with federal law.

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

These regulations contain numerous new provisions, outlined at the end of this letter, that require carriers

to survey providers and members on a variety of issues at different prescribed timeframes and we have commented on each in the attached. In sum, these provisions impose significant administrative requirements, 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 far more expansive than what exists today and what we see around the country. In particular, some of the proposed elements rely upon the necessary participation of enrollees and their recollection of events which are known to generate less reliable and accurate data than that produced by provider surveys. In fact, it appears to us that the MIA acknowledges potential issues with enrollee surveys by applying a weighted average to these surveys of 25% compared to that associated with direct provider contact of 75%.

Additionally, as discussed in the attached, we question whether some of these provisions would provide to the MIA the data it needs to ensure carrier compliance with network adequacy standards. Rather than imposing this breadth of untested audit requirements on carriers, providers, and enrollees, we reiterate our previous recommendation for the MIA to explore alternative regulatory solutions that we reference in the attached to measure network adequacy. 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.

(3) Leveraging the Uniform Credentialing Form and Expanding Provider Authority

Several new data points requested in these regulations are not part of the MIA's Uniform Credentialing Form (COMAR 31.10.26). The Uniform Credentialing Form is one of the few tools the MIA presently has to influence the information that providers uniformly provide to carriers prior to entering a carrier's network. Instead of creating new reporting requirements that can only be ascertained through various carrier surveys of providers, the MIA should consider enhancing this Form to include collection of specified information from providers, that might otherwise be obtainable only through surveys or not at all. This would help the MIA collect more accurate and complete network adequacy data than surveys alone. Provider classifications in the regulations should also be consistent with those set forth in the Uniform Credentialing Form's licensure categories, to allow for consistent reporting standards.

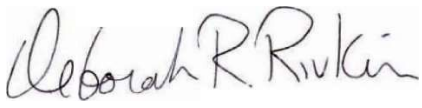
In addition, these regulations add new provisions to require carriers to elicit information from providers that it appears the MIA currently lacks the statutory authority to request itself. We respectfully suggest, consistent with our previous comments on this subject, that carriers do not have the power to compel provision of this information in all circumstances, and the MIA should explore whether legislation to expand its authority over providers for information concerning the provision of appropriate access and care to consumers, or legislation to expand oversight of the Boards of Physicians, Nursing, and others over providers with respect to the provision of appropriate access and care to consumers, is a more efficient and accurate way to obtain specified information.

(4) Telehealth Credits

We are generally supportive of the concept to provide telehealth credits for travel distance and appointment wait times but need a better understanding of how these credits will work in practice prior to offering more substantive comments. As noted in the attached, we would encourage the MIA to provide a detailed example outlining how the telehealth credits will be operationalized.

We look forward to continuing the discussion on these matters and other ideas concerning the draft proposed regulations. Please reach out should you have any questions on our comments.

Sincerely,



Deborah R. Rivkin

Title 31 MARYLAND INSURANCE ADMINISTRATION

Subtitle 10 HEALTH INSURANCE — GENERAL

Chapter 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) "Drug and alcohol treatment program" means any organization or individual certified by the Maryland Department of Health in accordance with Title 10, Subtitle 47 of COMAR.

[(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.

[(16)**]** *(20)* – **[**(21**]** *(25)* (text unchanged)

(26) "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 State Department of Education.

[(22)**]** *(27)* – **[**(23)**]** *(28)* (text unchanged)

[(24)**]** *(29)* "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)**]** *(30)* – **[**(26)**]** *(31)* (text unchanged)

[(27)**]** *(32)* "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) Continuity of care;

(b) Individuals with physical or mental disabilities, including physical access issues; 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 shall identify, by zip code, the number of participating providers for 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 calculation 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 three 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 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-5of the Public Health Service 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 are 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 §F of this regulation, all enrollees with a residence in a zip code where less than 100% 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 §F 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 §F 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,

(i) The total dollar amount paid by the carrier for out-of-network claims received in that category; and

(ii) The total billed charges for out-of-network claims received in that category;

(f) 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 entered between the carrier and an out-of-network provider; and

(vi) 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

(g) Any additional information deemed necessary by the carrier to provide context for the information described in §C(3)(a)-(f) 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 wait time or distance of participating providers;

(b) The total number of complaints made by providers, whether or not under contract, relating to the wait 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, a hand physical therapist, or specific durable medical equipment;

(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 the number of participating providers by zip code for certain provider type codes and specialty codes listed on the uniform credentialing form described in Insurance Article, § 15-112.1, Annotated Code of Maryland, if the Commissioner notifies the carrier in writing and identifies the particular provider type codes and specialty codes that shall 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 physicians, including pediatricians, family practitioners, and internists, 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, the geographic area data described in §C(3) of this regulation shall be reported based on the enrollee's place of employment, if the enrollee gains eligibility for participation in the plan due to place of employment.

[.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, 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 *practicing location of the provider or facility to the* enrollee's place of residence**[.]***; 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 practicing locations of every participating provider within the geographic area served by the carrier's network or networks;

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

(e) 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:			
Allergy and Immunology	15	30	75
Applied Behavioral Analyst	15	30	60
Cardiovascular Disease	10	20	60
Child Psychiatry	*10*	*25*	*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
Geriatric Psychiatry	*10*	*25*	*60*
Gynecology, OB/GYN	5	10	30
[Gynecology Only	15	30	75**]**
Licensed Clinical Social Worker	10	25	60
Licensed Professional Counselor	*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
Physician Certified in Addiction Medicine	*10*	*25*	*60*
Plastic Surgery	15	40	90
Podiatry	10	30	60
Primary Care Physician *(non-pediatric)*	5	10	30
Psychiatry	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
Ambulatory Infusion Therapy Centers	*10*	*30*	*60*
Critical Care Services — Intensive Care Units	10	30	100
Diagnostic Radiology	10	30	60
Drug and Alcohol Treatment Program	*10*	*25*	*60*

Inpatient Psychiatric Facility	15	45	75
Outpatient Dialysis	10	30	50
[Outpatient Infusion/Chemotherapy	10	30	60**]**
Outpatient Mental Health Clinic	*15*	*30*	*60*
Outpatient Substance Use Disorder Facility	*15*	*30*	*60*
Pharmacy	5	10	30
Residential Crisis Services	*10*	*30*	*60*
Skilled Nursing Facilities	10	30	60
Substance Use Disorder Residential Treatment Facility	*10*	*25*	*60*
Surgical Services (Outpatient or Ambulatory Surgical Center)	10	30	60
[Other Behavioral Health/Substance Abuse Facilities	10	25	60**]**
All other licensed or certified facilities under contract with a carrier not listed	15	40	90

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, 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 *practicing location of the provider or facility to the* enrollee's place of residence or place of employment from which the enrollee gains eligibility for participation in the group model HMO's health benefit plan**[**.**]***; 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 practicing locations of every participating provider within the geographic area served by the group model HMO's network or networks;

(ii) Identify 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;

(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) 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.

(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 §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.

(f) 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:			
Allergy and Immunology	20	30	75
Applied Behavioral Analyst	15	20	60
Cardiovascular Disease	15	25	60
Child Psychiatry	*15*	*30*	*75*
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
Geriatric Psychiatry	*15*	*30*	*75*
Gynecology, OB/GYN	15	20	45
[Gynecology Only	15	30	60**]**
Licensed Clinical Social Worker	15	30	75
Licensed Professional Counselor	*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
Physician Certified in Addiction Medicine	*15*	*30*	*75*
Plastic Surgery	15	40	90
Podiatry	15	30	90
Primary Care Physician *(non-pediatric)*	15	20	45
Psychiatry	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
Ambulatory Infusion Therapy Center	*15*	*30*	*60*
Critical Care Services-Intensive Care Units	15	30	120
Diagnostic Radiology	15	30	60
Drug and Alcohol Treatment Program	*15*	*30*	*60*
Inpatient Psychiatric Facility	15	45	75
Outpatient Dialysis	15	30	60
[Outpatient Infusion/Chemotherapy	15	30	60**]**
Outpatient Mental Health Clinic	*15*	*30*	*60*
Outpatient Substance Use Disorder Facility	*15*	*30*	*60*
Pharmacy	5	10	30
Residential Crisis Services	*15*	*30*	*60*
Skilled Nursing Facilities	15	30	60
Substance Use Disorder Residential Treatment Facility	*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)***[**at**]** *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 three 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 wait 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 monitor availability of providers, a carrier shall:

(a) Utilize a survey tool with enrollees;

(b) 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

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

(4) The survey tool described in §A(3)(a) of this regulation shall:

(a) Utilize a statistically valid method to ensure that survey respondents are selected in a random manner;

(b) Ask enrollees to provide the time period from the date of the initial request for each appointment type listed in §A(2) of this regulation to the earliest date offered for an in-person appointment with a participating provider possessing the appropriate skill and expertise to treat the condition; and

(c) Ensure a minimum sample size of responsive answers for each appointment type listed in §A(2) of this regulation that is equivalent to the lesser of:

(i) Ten percent of claims received by the carrier for that appointment type in the preceding calendar year; or

(ii) One hundred answers.

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

(a) Ten 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.

(6) The median wait times described in §A(2) of this regulation shall be calculated by:

(a) Determining the median wait time based on the results of the enrollee surveys described in §A(3)(b) of this regulation and multiplying that number by 0.25;

(b) Determining the median wait time based on the direct contacts with provider offices described in §A(3)(c) of this regulation and multiplying that number by 0.75; and

(c) Adding the results in §A(6)(a) and §A(6)(b) 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 enrollee surveys and the direct contacts with provider offices described in §A(3)(a)-(b) 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% 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 *for medical services* **[** (including medical, behavioral health, and substance use disorder services)**]**	72 hours
Inpatient urgent care for mental health services	*72 hours*
Inpatient urgent care for substance use disorder services	*72 hours*
Outpatient urgent care for mental health services	*72 hours*
Outpatient urgent care for substance use disorder services	*72 hours*
Routine primary care	15 calendar days
Preventive **[**visit**]** *care*/well visit	30 calendar days
Non-urgent specialty care	30 calendar

	days
Non-urgent mental health care	*10 calendar days*
Non-urgent **[**behavioral health/**]** substance use disorder **[**services**]** *care*	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) 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 the enrollee's place of residence or, 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 from the practicing location of the nearest provider to the enrollee's place of residence or, for 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% 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% of appointments

in each category, a carrier may apply a telehealth credit of up to 10% 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; and

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

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

(v) 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 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 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) of this regulation:

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

(b) 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;

(c) 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

(d) 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)(b) 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 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 detailed 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, 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**]** *Provider Type*			
[Specialty Provider**]** *Facility Type*			

(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% 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.*

(h) 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*, list the **[**percentage of enrollees for which the carrier met the appointment wait time standards**]** *calculated median wait time to obtain an appointment with a participating provider*, in the following format:

Appointment Waiting Time Standard Results	
Urban care *for medical services* **[** — within 72 hours**]**	
Inpatient urgent care for mental health services	
Inpatient urgent care for substance use disorder services	
Outpatient urgent care for mental health services	

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

(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% of appointments in any category, the carrier may include a statement on the executive summary indicating that the enrollee may obtain a timelier covered appointment than the median reported wait time for that category if telehealth is elected.*

(c) If the carrier arranges for telehealth services to be provided from participating providers on a 24/7 basis 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)