



December 4, 2020

Director of Regulatory Affairs
The Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Emailed to: InsuranceRegReview.mia@maryland.gov

Dear Director of Regulatory Affairs:

Thank you for the opportunity to submit comments on the Maryland Insurance Administration's (MIA) draft proposed revisions to the Maryland Network Adequacy regulations, COMAR § 31.10.44. The following comments are submitted by the Legal Action Center and the eleven (11) undersigned members of the Maryland Parity Coalition. The Center is a law and policy organization that fights discrimination, builds health equity, and restores opportunity for individuals with substance use disorders, criminal records, and HIV or AIDS. The Center leads the Maryland Parity Coalition – a group of advocates, consumers, and providers of mental health (MH) and substance use disorder (SUD) care – which has been actively involved in the development of the network adequacy regulations and has focused on ensuring that carriers comply with the Mental Health Parity and Addiction Equity Act (Parity Act) in the development of their provider networks and all other plan features.

We commend the MIA on proposing standards that (1) respond to the need for uniform data gathering and reporting standards as well as more frequent and detailed disclosures of appointment wait time data to regulators and members; (2) ensure more granular tracking and reporting of network coverage of MH and SUD services; and (3) focus on network coverage for underserved communities, including individuals with disabilities and limited English proficiency, individuals from all racial and ethnic communities, and those of all genders, gender identities and sexual orientations. As described in greater detail below, we strongly support the following proposed revisions:

- Inclusion of additional MH and SUD providers and facilities that must be tracked under the geographical distance metric;
- Heightened standards for the inclusion of essential community providers of MH and SUD services;
- Greater granularity in appointment wait time reporting for MH and SUD urgent and non-urgent services;
- New data reporting requirements that include reporting the number of providers by Board specialty, out-of-network costs to members when a network provider is not available, zip-code level impact for failure to meet geographical distance requirements, and consumer and provider survey data for appointment wait time compliance; and
- Mandatory submission of waiver information if a carrier fails to meet one or more metric.

These provisions appropriately address the lessons learned from the past three-years of carrier reporting and the MIA's enforcement efforts. They will allow consumers to better understand the network coverage for MH and SUD services, ensure greater transparency regarding the reasons for network deficiencies, increase stakeholders' ability to resolve the underlying problems, and improve overall access to care.

Notwithstanding these and other significant proposed revisions, we are concerned that the proposed telehealth standard would "get ahead" of carrier telehealth practices, technology availability, and broadband access in many locations across Maryland. In addition, this proposed standard would allow a carrier to satisfy the appointment wait time metric via telehealth without any data on the portion of members who would elect to get their medical care in this manner, let alone have the resources and technological infrastructure to do so. Thus, this critical metric could be satisfied without plan members gaining real access to services. As noted below, the current telehealth standard, which takes into consideration a consumer's election of telehealth services, should remain in place as additional data is gathered to determine carrier utilization of telehealth and the parameters of telehealth services.

I. Definitions - § 31.10.44.02

The proposed rule would add or revise several definitions, including "drug and alcohol treatment program," "essential community provider," and "waiting time," that we fully support. While the substantive implications of these definitions are addressed below, we wish to highlight our support for the following:

- Clarification in the definition of "essential community provider" that "behavioral" health services mean "mental" health services. The term "behavioral health" is often used to encompass both mental health and substance use disorder services, but, as used in the current regulations, can create confusion in reporting because substance use services are identified separately from "behavioral health" services. We support this same clarification that has been made throughout the substantive standards.
- Clarification in the "waiting time" definition that the appointment must be with a provider that has the "appropriate skill and expertise to treat the condition." This revision is particularly important for MH and SUD services, which, like other medical conditions, require specific skill and training to treat specific disorders but are not sufficiently distinguished under a generalized practitioner type. Thus, the availability of "a" MH or SUD provider does not satisfy the member's right to obtain network health services within the designated wait time if that provider lacks the expertise to treat the member's condition. This necessary distinction has important implications for the member's right to seek approval to obtain services from a non-participating provider, under Ins. § 15-830.

Additionally, the revision to the definition of "telehealth" to adopt the meaning of the term in Ins. § 15-139 would ensure consistency with any future legislation that may expand the platforms by which telehealth services are delivered. While this proposed definition revision, standing alone, has limited consequence, we are concerned that the proposed telehealth provision in § 31.10.44.06(B)(3) would make significant substantive revisions to the use of telehealth to satisfy the appointment wait time metric in advance of the 2021 General Assembly debate on this issues. As noted below, we believe this proposed telehealth revision is premature.

II. Network Adequacy Standards – § 31.10.44.03

We support the proposed inclusion of an affirmative statement of each carrier’s obligation to meet specific standards of network adequacy and to articulate that obligation as it applies to the full range of health plan members, including individuals with mental and physical disabilities, individuals with limited English proficiency, from diverse cultural and ethnic backgrounds and across all genders, sexual orientations, and gender identities. We recommend several revisions to clarify the obligations under this new provision.

A. Sufficiency Standards – § 31.10.44.03(A).

1. Referral Requirements

We support the requirement that a carrier clearly define and specify referral requirements to specialty and other providers (§ 31.10.44.03(A)(2)), but seek clarification on two points: (1) the relationship between this proposed requirement and a carrier’s obligation under Ins. § 15-830 to establish and implement a procedure to provide a standing referral to a specialist, including an obstetrician, and a referral to a non-participating specialist when a network is inadequate; and (2) the method, timing, and form by which the carrier must provide this information to members. **First, we believe that a carrier’s referral obligations under § 15-830 should be clearly conveyed to members, and we urge the MIA to clarify this proposed regulatory standard by explicitly referencing § 15-830 in § 31.10.44.03(A)(2).** Members who seek MH and SUD services are often unaware of their right under Ins. §15-830 to request approval to see a non-participating provider when a participating provider is not available. This prevents members from accessing appropriate care through a single case agreement and forces them to shoulder unaffordable out-of-network costs.¹

Second, we believe that the regulations should clearly identify the method, timing, and form by which carriers notify members of the plan’s referral requirements. Referrals under § 15-830 implicate different health care needs and carrier interests and engagement. A referral to a specialist or obstetrician, on the one hand, will likely involve a network provider and the standing referral allows for a more streamlined administrative process. On the other hand, a referral that is made because a network provider is not available requires identification of a non-network provider and reimbursement negotiation by the carrier. To fully inform members of their rights in these different contexts, a different notification process may be required. **We urge the MIA to require carriers to provide members with both a general notification of referral rights in print and electronic formats and an individualized notice to members who cannot access a network provider in a timely manner.** This distinction is particularly important for purposes of tracking out-of-network costs to members when network providers are not available, under proposed COMAR § 31.10.44.03(B)(2).

2. Culturally Competent Services for Enrollees

We support the requirement that providers ensure that all enrollees, as designated in § 31.10.44.03(A)(5), receive culturally competent care. **We recommend that (A)(5)(b) be**

¹ The Maryland Parity Coalition has sought enactment of legislation to ensure that carriers inform members of their right to request approval to see a non-participating provider when a network provider is not available within a reasonable time and distance and to ensure that members pay no more than the in-network cost of care under these circumstances. *See* SB 484/HB 1165 (2020).

revised to specifically identify diverse “racial” backgrounds in addition to cultural and ethnic backgrounds. The COVID-19 epidemic has highlighted long-standing racial disparities in access to health care that are grounded in structural racism. Black and brown patients report the importance of receiving medical services from a practitioner who shares their racial background and life experience,² and patients are “more satisfied with the services rendered by physicians of their own racial and ethnic heritage.”³ Steps must be taken to ensure that a carrier’s network includes providers of all races, and the collection of racial data is needed to assess a carrier’s efforts and progress.

3. Number of Providers by Board Specialty

We support the requirement that carriers report, in their access plans, the number of providers by Board specialty. We recommend three revisions to the proposal. **First, we recommend that the MIA identify the State licensure boards rather than the national licensure boards, since practitioners must be licensed in Maryland to practice in the state (with few exceptions). Second, although the provision makes clear that the list of Boards is not exhaustive, we recommend that the State Board of Professional Counselors and Therapists and the State Board of Social Work Examiners be explicitly identified in the regulatory provision.**⁴ Inclusion of these additional Boards will respond to the recognized gaps in network MH and SUD providers.

Third, and most important, **we recommend that the MIA require carriers to report, in addition to the number of providers in the network, the number of providers who have billed for services within the past 4-6 months.** The number of practitioners who actively bill for patient services is more reflective of a member’s access to health services than the number of practitioners who are licensed by a Board. Consumers commonly complain about the time-consuming process of contacting providers who, while listed as a network member, are inactive or non-practicing practitioners. The inclusion of this additional information will help members as they seek network services and more accurately reflect the breadth and robustness of a carrier’s network.

B. Monitoring Sufficiency Standards – § 31.10.44.03(B).

We support the proposed requirements in § 31.10.44.03(B) that carriers monitor network compliance on a frequent and on-going basis (at least monthly) and monitor and report, on a quarterly basis to the MIA, out-of-network costs incurred by members when network providers are not available. We offer several recommendations regarding the implementation of these important requirements.

² Emily P. Terlizzi, et al., “Reported Importance and Access to Health Care Providers Who Understand or Share Cultural Characteristics with Their Patients Among Adults, by Race and Ethnicity,” NATIONAL HEALTH STATISTICS REPORTS (Oct. 8, 2019), <https://www.cdc.gov/nchs/data/nhsr/nhsr130-508.pdf> (p. 3).

³ Jordan J. Cohen, et al., “The Case For Diversity in the Health Care Workforce,” HEALTH AFFAIRS, Vol. 21, No. 5 (Sept/Oct 2002), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.21.5.90>.

⁴ If the MIA retains the national board designation, we recommend that the American Board of Professional Counselors and American Board of Licensed Clinical Social Workers be included.

1. Monthly Monitoring of Compliance

We agree that on-going monitoring of network compliance is necessary to ensure that members have adequate access to providers on a consistent basis and that changes in provider participation or the number or location of covered members are taken into account and, if necessary, addressed on a real-time basis. A carrier's administrative oversight should flag gaps that will help prepare its frontline staff to better assist members as they seek providers for specific services. We believe that a reporting requirement would bolster transparency and ensure that the information translates to improved access to care for members. **We recommend that the MIA require carriers to report, in their annual access plan, the results of their monthly monitoring effort and steps taken to address deficiencies.**

2. Quarterly Reporting of Out-of-Network Costs to Members

We also agree that regular monitoring and reporting of out-of-network costs to members is essential to address the cost-shift to members when a carrier's network is inadequate. Data have revealed that Marylanders utilize out-of-network providers for MH and SUD services at a significantly higher rate than for medical services.⁵ This proposed requirement would call upon carriers, who have the most current utilization and reimbursement data, to track this trend and the financial burden on members. **We support the MIA's proposal to require quarterly reports on a standardized form and urge the MIA to include uniform definitions and standardized methods of calculating out-of-network costs so that meaningful data are collected.**

For purposes of the quarterly report tool, we are very interested in learning the MIA's plans for gathering accurate data and avoiding an undercount of consumer costs. We note, for example, that some portion of members will seek care from a non-participating provider after exhausting a search of network providers, without seeking the carrier's approval, because they are not aware of their rights. **We recommend that the MIA clarify that it seeks information for both those members who get a carrier's approval to see a non-participating provider and remain subject to balance billing under, Ins. § 15-830, as well as those members who go to a non-participating provider without seeking approval and pay the full cost of out-of-network care under their plan.** We suggest that the latter estimate can be ascertained, in part, from grievances that members have filed to challenge the carrier's refusal to pay for a service that was obtained from a non-participating provider because no network provider was available.

We also note that a certain portion of members may utilize their out-of-network benefit because their costs would be greater under a single case agreement and balance billing than their out-of-network benefit costs. Based on the experience of a coalition member who sought MH services, one carrier offered a reimbursement rate to a non-participating provider under a single case agreement that would have required the member **to pay more for the service, when balance billing is taken into account**, than under the member's out-of-network benefit. Thus, some portion of members use their out-of-network benefit to **save money**, even though

⁵ Steve Melek, et al., Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement, (Nov. 19, 2019), <https://www.milliman.com/-/media/milliman/importedfiles/ektron/addictionandmentalhealthvsphysicalhealthwideningdisparitiesinnetworkuseandproviderreimbursement.ashx>

they should be paying only the network rate for the service. We request that this practice also be taken into consideration when directing data collection and reporting by carriers.

Based on these consumer experiences, we request that the MIA require the collection and reporting of the following data points:

- The carrier’s process for informing members that they can request approval to see a non-participating provider under specific circumstances and its system for tracking this notification;
- The number of members who request approval to go to a non-network provider by specialty and the number of approvals by specialty;
- An estimated number of members who utilize an out-of-network provider without requesting the carrier’s approval;
- The number of single case agreements into which the carrier has entered by specialty;
- The carrier’s reimbursement to a non-participating provider under a single case agreement by service/specialty (and geographical region) as compared to the average negotiated contract rate for that service/specialty;
- The number of grievances/appeals challenging the failure to pay all or a portion of the cost of a non-network service at the same level as a network service, the number of denials and the resulting cost to members; and
- Demographic data, including race and age, of members who receive services from non-participating providers.

III. Filing of Access Plans – § 31.10.44.04

We support the proposed revisions to the access plan requirements and the proposed adoption of a standardized format for the information. We offer several recommendations to enhance the data collection requirements:

- The description of outreach efforts to recruit and retain providers of diverse cultural and ethnic backgrounds should also include “providers of diverse **racial backgrounds**.” (§ 31.10.44.04(C)(3)(b))
- The copies of policies and procedure documents that ensure that the network meets the needs of enrollees should also include “enrollees of diverse **racial backgrounds**” as well as diverse cultural and ethnic backgrounds. (§ 31.10.44.04(C)(3)(g)).

IV. Travel Distance Standards – § 31.10.44.05

A. Reporting Standards

We support the proposed revisions to the travel distance metric. The revisions effectively clarify the methodology for calculating travel distance and require more precise data on the areas of the state in which this metric is not satisfied as well as the number of enrollees who reside in those zip codes. This additional information enhances our understanding of service access far beyond the current aggregate reporting by urban, suburban, and rural areas, which can mask sub-region variations.

We also support the MIA’s efforts to require carriers to identify how public transportation is taken into account in zip codes in which a significant portion of the population does not own a personal automobile. To ensure a consistent analysis across carriers, **we recommend that the**

MIA define the term “significant portion” of the population by zip code, taking into account variations in population density in urban and rural areas of the state, and require carriers to identify the availability of public transportation in affected zip codes.

B. Mental Health and Substance Use Disorder Providers

We also support the proposed revisions that will allow for far better tracking of MH and SUD providers across the continuum of care. Specifically, we support the inclusion of additional provider and facility types for MH and SUD services including: child psychiatry, geriatric psychiatry, licensed professional counselors, physicians of addiction medicine, drug and alcohol treatment programs, outpatient mental health centers, outpatient substance use disorder facilities, and substance use disorder residential treatment facilities. We note that “drug and alcohol treatment programs” encompass both outpatient SUD facilities and residential SUD facilities, and, thus, the inclusion of all three provider types will likely create confusion in reporting. **To avoid duplicative counting of facilities, we recommend that the term “drug and alcohol treatment programs” be removed and replaced with Opioid Treatment Programs (OTPs)⁶ to ensure tracking of this important provider type. If this revision is adopted, the term Outpatient Substance Use Disorder Facility should be clarified to cover SUD facilities that are not licensed OTPs.**

We also note discrepancies in several distance metrics for MH and SUD providers. First, the designated travel distance for Outpatient Substance Use Disorder facilities in suburban regions is 30 miles, while the designated travel distance for all other SUD provider types and facilities (including Drug and Alcohol Treatment Programs) is 25 miles in the suburban region. **We recommend aligning the travel distance for Outpatient Substance Use Disorder facilities at 25 miles for suburban regions.** Similarly, for Group Model HMOs, we note that the designated travel distance for Child Psychiatry and Geriatric Psychiatry in rural areas (75 miles) differs from that for Psychiatry and Psychology (60 miles). The travel distance for Licensed Clinical Social Workers and the newly proposed Licensed Professional Counselors is also designated as 75 miles for rural area. **We recommend that the travel distance for all MH provider types be aligned with Psychiatry and Psychology for rural regions, consistent with the requirements for non-Group Model HMO plans.**

Second, we support the proposed targeted reporting of the portion of SUD facilities that offer services for alcohol treatment only, drug treatment only, or both alcohol and drug treatment. § 31.10.44.05(A)(1)(d)(iii). That said, we expect that few SUD facilities offer alcohol or drug treatment alone, as most programs treat a substantial number of patients with multi-drug use disorders, which include alcohol and other drugs. A far more important data point would be the portion of outpatient and residential SUD facilities that offer adolescent services or adult services. Maryland has a dearth of adolescent programs, particularly residential services, and families must routinely seek care from non-participating providers in other states. **We, therefore, recommend that carriers be required to report, in their access plans, the portion of facilities that offer adolescent services by setting of care (either outpatient and/or inpatient).** This proposed addition, along with reporting the availability of child psychiatrists, will provide a better assessment of access to youth and adolescent SUD services.

⁶ We have learned that provider networks in western Maryland do not include a sufficient number of OTPs, which inhibits access to SUD care. By tracking this facility type, strategies to address that gap can be identified.

Similarly, few commercial carriers contract with residential crisis services (RCS), despite RCS being a mandated benefit for almost 20 years in Maryland. Ins. § 15-840. Limited progress was made following a 2019 workgroup chaired by Delegate Pena-Melnyk and attended by MIA staff and carrier representatives, but the majority of carriers continue to lack contracts with RCS providers. Carriers should be required to report on the availability of RCS providers in their networks.

Finally, we strongly support the proposed revision to the essential community provider (ECP) standard (§ 31.10.44.05(C)), which would require the inclusion of 30% of available ECPs of MH services, SUD services, and medical services (calculated separately) in each of the urban, suburban, and rural areas. This heightened network requirement should result in the inclusion of additional community-based SUD and MH treatment providers that serve lower income individuals and ensure continuity of care for those who move from Medicaid to private insurance coverage.

V. Appointment Wait Time Standards – § 31.10.44.06

We strongly support the proposed revisions to the appointment wait time standards that would provide far greater granularity in reporting the availability of urgent and non-urgent services for MH and SUD treatment, increase transparency on appointment availability for consumers, and establish a uniform methodology for calculating compliance with the wait time metric. We also support the proposed sufficiency standards that would require a quarterly review of compliance, based on both a member survey and direct contact with providers, and a requirement that carriers notify the MIA of deficiencies in their networks and corrective action plans.

We have strong reservations, however, about the proposed telehealth standard, which is not aligned with the questions that would be posed on the member survey. The proposed standard could arguably obviate the rest of the newly proposed standards, which would shed significant light on the timely availability of MH, SUD, and other medical services. **While we agree that telehealth services should be considered in the satisfaction of the appointment wait time metric, as currently permitted under the regulations, more information and data are required to support the proposed standard that would eliminate consumer choice in the mode of service delivery.**

A. Appointment Wait Time Categories and Standards

We fully support the proposed categories for appointment wait time calculations and the retention of the specific wait time standard for each type of service. The disaggregation of medical, MH, and SUD services in the “urgent care” services category as well as the disaggregation of MH and SUD services for “non-urgent care” will provide a more complete understanding of service gaps. We also support the separate designation of inpatient and outpatient urgent care services for MH and SUD treatment.

B. Monitoring Provider Availability – Proposed Methodology

We support the proposed methodology to calculate appointment availability through both a member survey and a provider office direct contact survey and to weigh the survey results at 25 percent and 75 percent, respectively. Although we defer to experts in the development of survey tools, we note that all carriers must collect information in a uniform manner to ensure

accurate and usable data. Providers participate in multiple carrier networks, and they should be reporting their data in the same way for all provider direct contact surveys, regardless of the carrier. **We offer several recommendations to achieve uniformity:**

- We urge the MIA to create forms that carriers must use for both the member survey and the provider contact survey and provide the text of the question(s) to be posed. The forms/spreadsheets can be developed so that calculations are auto-calculated based on the data entered. Such forms will facilitate data collection, calculations, and the MIA's review of data. In addition, an instruction guide that addresses anticipated questions would ensure uniformity in data gathering.
- We urge the MIA to identify the methodology for randomly selecting members for the member survey and, most important, **require the inclusion of only those members who have filed an insurance claim for the designated service category and have done so in the past year.** Some members will not use their insurance to pay for services and, thus, will not provide information that is reflective of the experience of members who do seek to use their insurance for the service.
- We urge the MIA to identify the methodology for randomly selecting providers in each of the service areas for direct contact and **to ensure that the pool of providers includes those who have actively billed for the designated service within the past 4-6 months and that a cross-section of provider offices are contacted as opposed to multiple practitioners in a single office.**
- We agree that the "median" wait time will most accurately reflect provider availability, **but we also recommend that the MIA require reporting of the "average" wait time to determine, at least initially, the spread across providers.** This may be particularly useful for non-urgent specialty care that will cover a wide range of practitioners.

The proposed regulations require the member to retain documentation of their survey efforts (§ 31.10.44.06(A)(3)(d)) rather than submit the data report to the MIA. We recognize that carriers will gather this data on a quarterly basis, under § 31.10.44.06(B)(1), and that the need for regulatory oversight must be balanced against the administrative burden on the MIA. At the same time, the proposed regulations would not require the carrier to engage an external vendor to conduct an independent review or verification of the data, as required by other states such as the California Department of Managed Health Care. **We believe that some oversight is needed, particularly because the carrier would be required to make this data available to members on a quarterly basis, under § 31.10.44.06(A)(2). We, therefore, recommend that carriers be required to submit their quarterly reports to the MIA with an attestation that the report has been subject to a quality assurance review and signed by the plan's chief executive officer.**

We also fully support the proposed requirement that carriers make their quarterly wait time reports available to members. § 31.10.44.06(A)(3)(d). **To ensure that the information is reported and shared in a uniform manner by all carriers, we recommend that the MIA provide instructions for the posting of specific information on the carrier's website and in print form.**

Finally, we urge the MIA to require carriers to evaluate the availability of network providers who treat patients with more complex MH conditions that require longer-term treatment, including individuals with co-occurring MH and SUDs. While we have worked

with individuals with rare medical conditions who have no difficulty finding network practitioners in a timely manner, individuals with MH conditions who are considered to present more risky health conditions, including individuals with histories of suicide attempts, trauma and co-occurring substance use or medical disorders, are frequently unable to identify network providers with the requisite skill and expertise. This patient population can impose high costs to health plans if not provided appropriate and affordable network care, and they should have access to network care on the same basis as members with rare or higher risk medical conditions.

C. Sufficiency Standards

We fully support the proposed reporting requirements of network deficiencies within 10 business days of the quarterly evaluation, including the carrier's corrective action plan, and quarterly reports of complaints related to provider unavailability. §§ 31.10.44.06(B)(2) and (F). **We offer several recommendations to ensure uniformity across carriers.**

- In addition to requiring carriers to submit their quarterly wait time reports, **we recommend that the MIA establish a date deadline by which a deficiency report and action plan must be submitted.**
- We agree that a carrier must develop an action plan to address deficiencies, but, in recognition that system corrections may take time, **we recommend that that the carrier be required to identify how it plans to make services available to members at no greater cost than a network service and demonstrate that its proposed solution(s) are compliant with the Parity Act.** In Parity Act market conduct surveys, carriers have reported that they allow members to get services from a non-participating provider under these circumstances. This "solution" has a disparate effect on members seeking MH and SUD services, as they utilize non-network services at a far greater rate for MH and SUD services than for medical services and are subject to balance billing for those services. **Carriers must identify solutions that ensure members receive contracted plan benefits as remedial steps are implemented.**

We also note that the MIA has proposed to revise the threshold for satisfaction of the wait time metric from 95% of plan members to 90%. We cannot anticipate the practical implications of this proposed change and note that most states do not establish a threshold for satisfaction of this metric.⁷ See Legal Action Center, Supplemental Comments on Maryland Network Adequacy Regulations (Aug. 19, 2020), Attachment A. To offer an assessment of this proposed revision, we request that the MIA describe its rationale for the lower threshold. **We also recommend that the threshold for compliance purposes be retained at 95% and that carriers be required to submit the 10-day report when the rate of satisfaction falls below 90%. Additionally, the adoption of the lower threshold for reporting purposes would make it more important to require the carriers to submit their quarterly reports on wait time data to the MIA so that regulators can assess the impact of the lower threshold.**

D. Use of Telehealth to Satisfy Appointment Wait Time Metric

The proposed revisions would adopt a substantially different telehealth standard, permitting a

⁷ We note that Colorado requires a 100% threshold for emergency and urgent care services and a 90% threshold for primary care, MH/SUD routine care, prenatal care, primary care access to after-hours care, preventive visits/well care and non-urgent specialty care.

carrier to count telehealth visits in satisfaction of the appointment wait time metric as long as the telehealth service is “clinically appropriate, available and accessible” to an enrollee. § 31.10.44.06(B)(3). The propose regulation does not define “clinically appropriate,” “available,” or “accessible” and would remove the current requirement that a member must elect to utilize the telehealth appointment. As noted above, we agree that carriers should be permitted to count telehealth appointments for purposes of the appointment wait time metric, as currently permitted, but we believe the proposed telehealth standard revision is both premature and insufficiently protective of plan members for several reasons.

- The lack of definition for “clinically appropriate,” “available” and “accessible” would allow each carrier to define those terms, establishing different and non-transparent standards across carriers, and the regulations would provide no oversight of those standards.
- The limited utilization of telehealth by carriers to satisfy the appointment metric pre-pandemic provides no insight as to the geographical areas of the state and zip codes in which carriers have successfully used telehealth and the portion of members who have elected to use a telehealth service.
- Broadband services are not available to families in both rural and urban areas of Maryland, with an estimated 425,000 Marylanders lacking access to high-speed internet services,⁸ which impacts accessibility, and has a disproportionate impact on lower-income families and communities of color.⁹
- While the 2021 General Assembly will consider several bills that would expand the definition of telehealth to include audio-only telephonic services and address reimbursement rates, the fate of such proposals will determine whether, and the degree to which, telehealth services may be more available and accessible to Marylanders in the future.
- Consumers, in consultation with their providers, should *always* determine whether a telehealth appointment is clinically appropriate and the frequency with which services are delivered in that manner. The health care choices that a member makes in the context of COVID-19 may not reflect the choice a member will make post-pandemic.

We, therefore, urge the MIA to retain the current telehealth standard that allows carriers to count such appointments for satisfaction of the appointment wait time metric if the member elects that mode of service delivery. We also recommend that the MIA begin to collect data from carriers that would inform any future expansion of this standard. We believe that the following data points are relevant:

- Member interest in using telehealth services for each type of service covered by the wait time metric, which could be gathered as part of the member survey, under § 31.10.44.06(A)(4).

⁸ Bruce DePuyt, With Digital Divide Starker Than Ever, More Than 400K Marylanders Lack Broadband, Maryland Matters (Oct. 6, 2020), <https://www.marylandmatters.org/2020/10/06/with-digital-divide-starker-than-ever-more-than-400k-marylanders-lack-broadband/>.

⁹ In Baltimore, as estimated 96,000 households (40.7%) did not have wireline internet services, as of 2018, and an estimated 75,000 households (1 in 3) – mostly lower income – did not have either a desktop or laptop computer. Abell Brief, Baltimore’s Digital Divide: Gaps in Internet Connectivity and the Impact on Low-Income City Residents. (Summer 2020), <https://abell.org/publications/baltimores-digital-divide-gaps-internet-connectivity-and-impact-low-income-city>.

- Practices that will ensure that members are aware of their ability to access a provider via telehealth outside of their immediate geographical area.
- Areas of the state and zip codes in which carriers intend to offer telehealth services and the services and specialties for which telehealth services would be available.

VI. Network Adequacy Waiver Standards – § 31.10.44.08

We fully support the proposal to require carriers that fail to satisfy one or more network adequacy metric to submit detailed information, set out in § 31.10.44.08(A), so that the MIA can assess each carrier’s efforts to improve its network and allow all stakeholders to identify and begin to address the cause of deficiencies. Over the past three years, carriers have either not requested waivers when they failed to meet network standards or have not submitted the required information in their waiver requests. Mandatory submission of the carrier’s efforts to contract with providers, incentives offered to providers to join the carrier’s network, initiatives that have been used to improve their network, and additional steps to avoid future deficiencies (among other information) will facilitate efforts to improve access and availability. **As two additional data points, we recommend that the MIA require carriers to submit (1) reimbursement rate data, including the carrier’s average and median contracted reimbursement rate, for provider specialties that are not sufficiently available in the network and (2) the number of single case agreements by specialty into which the carrier has entered.**

Additionally, we support the proposed requirement regarding the posting of network adequacy waivers that the MIA grants. § 31.10.44.08(B)(7). While we recognize that some information in the waiver submissions will be proprietary and not subject to disclosure, **we recommend that a summary of waiver submission information be made publicly available, so that providers and consumers gain an understanding of remaining barriers to achieving network adequacy.** That information is essential for policy development.

VII. Network Adequacy Access Plan Executive Summary Form – § 31.10.44.10

We fully support the development of a standardized executive summary form, the reporting of information about local health department participation in the carrier’s network, and clarification of essential community provider reporting (as noted above).

The proposed revisions to the network adequacy standards would address a wide range of concerns that the Maryland Parity Coalition has identified regarding the failure to include MH and SUD providers in carrier networks, significant gaps in access to MH and SUD services, and the inability to monitor carrier network practices. We commend the MIA for developing draft regulations that will advance enforcement of the regulatory standards and provide detailed information and data that will help stakeholders address access gaps over the long run.

Thank you for considering our views and recommendations, and we look forward to working with the MIA and all stakeholders throughout the regulatory process.

Sincerely,

A handwritten signature in cursive script that reads "Ellen M. Weber".

Ellen M. Weber, J.D.
Vice President for Health Initiatives

Addiction Connections Resources
Community Behavioral Health Association of Maryland (CBH)
Institutes for Behavior Resources, Inc.
Maryland Addiction Directors Council (MADC)
Maryland Association for the Treatment of Opioid Dependence (MATOD)
Maryland Coalition of Families
Maryland Hospital Association (MHA)
Maryland Psychiatric Society
Mental Health Association of Maryland
NAMI Maryland
NCADD-Maryland