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VIA EMAIL

August 21, 2017

Lisa Larson
Regulations Manager
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Re: Comments on Proposed Regulation 31.10.44 Network Adequacy

Dear Ms. Larson:

I write on behalf of CareFirst BlueCross BlueShield (CareFirst) to provide CareFirst's comments and recommendations to the Maryland Insurance Administration (MIA) in response to the July 21, 2017 proposed regulations for network adequacy for health insurers required under HB 1318.

With more than 43,000 providers in its PPO network and more than 38,000 providers in its HMO network CareFirst maintains the largest provider networks of any insurer in the region. In fact, the claims paid to network providers represent 97 percent of all medical claims paid by CareFirst. Given the breadth, depth, type and number of providers participating with CareFirst, our comments reflect our significant experience in managing, growing and maintaining robust provider networks. We believe our proposed changes to the regulations would promote and enhance network adequacy of health insurance products in the State, while minimizing unnecessary administrative burdens that do not significantly enhance access to care.

Below, please find our specific comments on the proposed regulations for your consideration.

1. **Wait Times Are Not an Accurate Measure of Network Adequacy and Should Not Be Included in the MIA Regulations**

As we have emphasized in meetings and written comments, we strongly urge the MIA to strike wait time standards from the proposed regulations.

First, as is fully detailed in our May 12, 2017 letter, appointment wait times can differ based on numerous factors that do not reflect the true size and breadth of a network and over which carriers have little to no control. It is providers, not carriers, who:

- Exclusively determine when to set appointment times and office hours;

- Exclusively establish how many patients they will see during office hours and how much time they will spend with each patient;
- Exclusively assess whether the requested appointment is for a routine visit, for the treatment of a chronic condition or for acute or urgent care; and
- Often practice in multiple locations so wait times in one location is solely affected by a providers own practice schedule.

Second, providers treat a large variety of patients, including self-pay, Medicare and Medicaid and patients who are members of other commercial carriers. For providers that contract with multiple payors, it is impossible for a carrier to control how quickly their member can get an appointment. CareFirst recognizes this in our provider contracts. We require providers to serve our members with the same professional standards of care with which such services are provided to all patients treated by the provider. Further, we require that the quality and availability of services will be no less than the quality and availability of services provided to all patients treated by the provider. This contract provision is a clear recognition that providers are not exclusively treating CareFirst members, they are providing services to patients insured with numerous carriers and therefore should treat all patients equally. This standard includes appointment wait times.

Third, it would be operationally impossible for carriers to measure and maintain accurate, up-to-date appointment wait time information for each provider in their networks without a corresponding obligation on providers to timely report and update this information to each carrier on a frequently recurring basis for the carrier to in turn then report it to members. An expectation to contact each participating provider on a recurring basis to determine appointment wait times causes undue administrative burden and costs on carriers, and such wait times would be useless as they constantly change.

Fourth, we have maintained and reiterate here that wait times can only be achieved with the participation and agreement of providers as they solely control their schedules and when they make appointments available to patients. CareFirst recommends that the MIA only include wait times in the regulations when the applicable Health Occupations Boards similarly issue regulations holding providers to the same wait time standards so that they can be enforced against providers and carriers equally.

We recently contacted several plans in other states that have implemented appointment wait times to better understand how these plans have collected and reported wait times. Every plan contacted reported that it has been extremely challenging to accurately collect, compile, and report appointment wait times. There is no indication that Maryland's experience will be any different—meaning it will likely be difficult, if not impossible, for regulators to measure compliance and compare plans across the industry, thereby rendering the measurement meaningless.

We urge that the Appointment Wait Time provision in the proposed regulation be removed until such time that there is evidence that the necessary data can be collected and measured easily and accurately. Instead, CareFirst strongly recommends that time and distance standards are a significantly stronger measure of network adequacy and accessibility of members to providers.

2. **Group Model HMO Plans Should Not Have Different Travel Standards Than Other Carriers' Provider Panels**

CareFirst has concerns about the notable difference in the proposed regulations between the geographic area distance requirements for Group Model HMOs and for all other types of health benefit plans even though both types of plans often contract with providers in the same manner. Group Model HMO plans in Maryland often contract with independent, non-affiliated providers and facilities in the community in addition to the providers that are employed by the Group Model HMO. Group Model HMO plans that contract with independent physicians and facilities located in the community and not exclusively within the traditional Group Model HMO framework should be held to the same geographic area distance requirements as all other plan types as their members have the same clinical needs regardless of their plan.

Below are examples of the inconsistency and sizeable differences in the required geographic access standards for providers and facilities, even though these providers and facilities are independent practices and facilities that contract with Group Model HMOs, just as they would with other insurers and HMOs. The policy reasons for why other insurers and HMOs should be held to the more stringent standards remain unclear.

	Urban Area Maximum Distance (miles)	Suburban Area Maximum Distance (miles)	Rural Area Maximum Distance (miles)
Oncology-medical, Surgical			
Group Model HMO Plans	15	30	60
All Other Types of Plans	10	20	60
General Surgery			
Group Model HMO Plans	20	30	60
All Other Types of Plans	10	20	60
Out-Patient Dialysis			
Group Model HMO Plans	15	30	60
All Other Types of Plans	10	30	50
Critical Care Services-Intensive Care Units			
Group Model HMO Plans	15	30	120
All Other Types of Plans	10	30	100

Moreover, CareFirst recommends in proposed COMAR 31.10.44.04 that the standard for geographic availability for all plans should be at least 90% of enrollees have access to at least one provider for the given specialty. Most other states and Medicare require this 90% adherence standard for travel requirements.

3. Network Adequacy Access Plan Executive Summary Form

The proposed regulations require carriers to report network sufficiency results based on certain metrics. For Travel Distance Standards, carriers must list the percentage of the participating providers by provider type for which the carrier met the travel distance standard listed. We request instead that the standard be measured by the percent of members that have access to a stated provider type. This approach is consistent with the NCQA national standards that carriers are already collecting. To change to a different standard will be unnecessarily burdensome and difficult.

We also suggest that if you decide to proceed with Appointment Wait Times, the measure used should be changed to the percent of members who received care within the stated timeframe.

4. Definitions and Scope of Provider Categories

CareFirst recommends the definition for "primary care physician" in proposed COMAR 31.10.44.02(B)(16) be changed to "primary care provider." This term is used in § 15-112. Additionally, "provider" is defined in § 15-112. Further, the definition in § 15-112 does not match the later definition of a physician in proposed COMAR 31.10.44.02(B)(20)(C). Both definitions should reflect allowing a primary care provider to be board certified or board eligible. The term "specialty provider" should be defined to capture physicians with the same practice specialty and other health care providers with the same type of license.

Moreover, it is inappropriate to include "Applied Behavioral Analysis" under the "Facility Type" category in proposed COMAR 31.10.44.04(A)'s geographic distance chart. Applied Behavioral Analysis is a type of habilitative service under COMAR 31.10.39.02 and not a type of facility. Therefore, it should be removed from the list of facility types.

Finally, the categories "Other facilities" and "Other Provider not listed" in the Chart of Travel Distance Standards in proposed COMAR 31.10.44.04 are too broad and should be defined. Measuring access to provider types that are not defined and assessing a carriers' compliance with an undefined standard will prove unnecessarily difficult and yield little consistent improvement to access especially if carriers define these terms differently.

We would be happy to discuss our comments further with you, and look forward to continuing this important work on network adequacy.

Sincerely,

Deborah R. Rivkin