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May 12, 2017

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

Re: Draft Proposed Network Adequacy Regulations

Dear Ms. Larson:

I write on behalf of CareFirst BlueCross BlueShield ("CareFirst") to provide CareFirst's recommendations to the Maryland Insurance Administration ("MIA") in response to the draft proposed regulations for network adequacy for health insurers as required under HB 1318.

With over 43,000 providers in its PPO network and over 38,000 providers in its HMO network, CareFirst maintains the largest network in the region. In fact, over 97% of all of our reimbursed medical claims were submitted to in-network providers. Given the breadth, depth, type and number of providers that participate with CareFirst, we believe the feedback provided below will promote network adequacy in the state without being too administratively burdensome or practically unattainable.

We must caution, however, given the dynamics at the federal level, this is a time of great uncertainty for health insurers and the consumers that we serve. Any regulations on this topic should balance the needs of consumers to have meaningful access to providers through their health benefit plan, while giving insurers the flexibility they need to design affordable and quality health benefit plans.

Recognizing the challenging environment in which health insurance carriers operate, there are recent examples of government entities re-examining network adequacy requirements in light of changing market conditions. Last month, the Centers for Medicare and Medicaid Services finalized a market stability rule that defers network adequacy regulation for 2018 to the states and alters the threshold of a state's Essential Community Providers that an insurer must have in network. In March, Connecticut's Exchange Board recently approved changes which included allowing carriers to pare back their networks in an effort to offset anticipated rate increases.

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Our specific recommendations to the draft regulations are below.

1. **Geographic Access Standards Should Be Modified, Including to Reflect Maryland's Geography and Recognized Provider Categories**

As was outlined in our February 1, 2017 comment letter to the MIA (attached), while we agree that the geographic standards adopted by the MIA should reflect the varying population density of Maryland, we do not believe the categories delineated in the draft regulation are easily workable for Maryland. Instead, we recommend that MIA define region types into three main categories.

Region Type	Population Density
Urban	> 3000 per square mile
Suburban	1000 – 3000 per square mile
Rural	<1000 per square mile

The urban/rural classification is also consistent with how the Maryland Department of Planning analyzes needs within the state. [1]

If, however, the MIA decides to utilize the four different geographic areas reflected in the draft regulation, we recommend that the MIA list all counties in the State that fall into each of the four designated regions. By doing so, there will be a consistent standard that is easily determined by all carriers, providers and interested parties.

CareFirst also has significant concerns regarding the designated specialty provider geographic area distance requirements put forth in the draft regulations. We recommend that "providers" should form the basis of the standards, rather than "services." When services are used rather than recognized categories of providers, the standards become too subjective, and thus difficult for carriers to meet. Further, the regulation should focus exclusively on provider types that are nationally recognized, and reflected in state licensure, certification or accreditation.

Of the states that have adopted geographic access standards, all but one enumerate generalized categories for primary care providers and specialists. As such, CareFirst recommends removing from the geographic access list in the draft regulation all services and programs, as well as sub-classifications of specialties, including "Cardiac surgery program," "Cardiac catheterization services," "Mammography," "Surgical services," "Outpatient infusion/Chemotherapy", and "Critical Care Services." Additionally, CareFirst has concerns that many of the specialties and provider types delineated in the draft regulation are too broad or are not based on nationally recognized standards, including "Other medical provider not listed" and "Other facilities". Measuring access to provider types that are not specified and assessing carriers' compliance with some of the proposed standards will prove difficult.

Within the three proposed geographic categories described above, we recommend the following access standards given our extensive breadth and depth of experience in developing networks to best serve our members:

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[1] See, for example, https://planning.maryland.gov/PDF/OurProducts/Publications/ModelsGuidelines/mg28.pdf.

Provider Type	Geographic Standard
Primary Care Practitioners	**Urban**: 2 adult and 2 pediatric primary care providers ("PCPs") within 5 miles of the member's residence **Suburban:** 2 adult and 2 pediatric PCPs within 10 miles of the member's residence **Rural:** 2 adult and 2 pediatric PCPs within 20 miles of the member's residence
High-Volume and High-Impact Specialists	**Urban:** 2 OB/GYN and 1 of each Orthopedic, Cardiology, Dermatology, Oncology, and Nephrology specialist within 5 miles of the member's residence 1 Psychiatrist within 8 miles of the member's residence **Suburban:** 2 OB/GYN and 1 of each Orthopedic, Cardiology, Dermatology, Oncology and Nephrology specialist within 10 miles of the member's residence 1 Psychiatrist within 18 miles of the member's residence **Rural:** 2 OB/GYN and 1 of each Orthopedic, Cardiology, Dermatology, Oncology, and Nephrology specialist within 30 miles of the member's residence 1 Psychiatrist within 45 miles of the member's residence
High Volume Behavioral Health Practitioners -Psychiatrists, Licensed Professional Counselors (including Alcohol and Drug Counselors) Social Workers, Psych Nurses, Nurse Clinical Specialists.	**Urban:** 1 behavioral health practitioner within 8 miles of the member's residence **Suburban:** 1 behavioral health practitioner within 18 miles of the member's residence **Rural:** 1 behavioral health practitioner within 45 miles of the member's residence

The draft regulations propose that for a carrier with a tiered network, a carrier's provider panel must meet the geographic access standards for the lowest cost-sharing tier. Maryland's physician rating system law already sets out significant requirements for carriers that have physician rating systems. As such, the provision relating to tiered networks is unnecessary and should be struck from the regulation.

We also note that there is a stark difference between the geographic area distance requirements for staff model HMO plans and for all other types of health benefit plans. Staff model HMO plans often contract with numerous providers in the community, in addition to the providers that they employ who practice in the HMO buildings, and should be held to the same geographic area distance standard to which all other plans are held. CareFirst recommends that the geographic area distance requirements should be consistent across all types of plans.

An example of the inconsistency is the sizeable differences in the required geographic access standard for OB/GYNs between two plan types. The policy reason for this difference is unclear.

OB/GYN				
	Large Metro Area Maximum Distance (miles)	Metro Area Maximum Distance (miles)	Micro Area Maximum Distance (miles)	Rural Area Maximum Distance (miles)
Staff Model HMO Plans	15	20	30	45
All Other Types of Plans	5	10	20	30

Finally, CareFirst recommends that these availability standards should be maintained by carriers for 90% of their members. The current 100% adherence standard in the proposed draft regulation would be impossible for any carrier to meet, as providers move both in and out of networks and move offices on a regular basis.

2. **Wait Times Are Not An Accurate Measure of Network Adequacy and Should Not Be Included in the MIA's Regulations**

We have expressed in previous oral and written testimony our numerous concerns with using wait times as a measure of network adequacy as wait times are not within the control of the carrier. Wait times quoted to a member by a provider can differ based on a number of factors which do not reflect the size and breadth of a network, including but not limited to the following:

- Providers (not carriers) determine when to set appointments and office hours;
- Providers (not carriers) establish how many patients they wish to see during their office hours;
- Providers (not carriers) determine the urgency to see the provider based on the patient's type of medical condition and the condition's severity;
- Providers (not carriers) assess whether the requested visit is for a screening, for the treatment of a chronic condition, or for acute care;
- Providers may see a large variety of patients, including self-pay patients, Medicare and Medicaid patients, and patients who are members of other carriers and therefore do not reflect the adequacy of a given commercial carrier's network, but the provider's entire universe of patients;
- Providers may not see patients on a regular basis in an office setting, and therefore have longer wait times that are not reflective of network adequacy, because they teach, perform surgeries, conduct research, or provide other types of services;
- Providers often practice in multiple locations, and so a wait time in one location is not indicative of a provider's availability elsewhere;
- Uniquely skilled providers (such as pediatric neurosurgeons) are not interchangeable with other providers, and so a long wait time to see a given provider is not indicative of a poor network nor does this recognize the value and importance to members of having these highly skilled providers in the network; and
- Provider wait times may vary throughout the year, such as where a pediatrician's office has a longer wait time at the end of summer and beginning of the school year.

Moreover, it would be operationally impossible for carriers to maintain accurate, up-to-date 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 wait times causes an undue administrative burden on carriers, and such wait times would be rendered meaningless as they constantly change.

If, however, the MIA decides to utilize the wait time standards as outlined in the proposed regulation, which CareFirst strongly opposes, we have concerns regarding how the provider specialty types are defined. As is the case in the geographic access standards, the wait time for provider specialties must reflect true specialty types, and not services. Further, if these standards were to be adopted, the term "Non-Urgent Ancillary Services" should be defined. Without a definition, this term is broad, unclear, and open to plan interpretation.

3. Provider-to-Enrollee Ratios Must Reflect Provider Type

Consistent with what is described above relating to geographic area distance standards and wait time availability standards, the provider-to-enrollee ratios in the draft regulations must accurately reflect provider specialty types, and not provider services. The term "services" is too broad and open to plan interpretation.

Further, the proposed regulation lists separately "Enrollees for mental health services" and "Enrollees for substance use disorder services." CareFirst recommends combining mental health services and substance use disorder services as the distinction between the two services may be unclear, and providers of this specialty may provide both services.

4. Waiver Request Requirements

CareFirst appreciates and strongly supports the availability of a waiver request which would allow the carrier a waiver of network adequacy requirements if the carrier demonstrates that a reasonable effort to contract with providers has been made, but certain circumstances out of the carriers' control impact the ability of a carrier to meet a specific network adequacy standard. Carriers should not be subject to MIA enforcement action for factors that are outside of carriers' control.

We recommend that the MIA include additional waiver factors in the regulation if the carrier can demonstrate evidence of good faith efforts to enroll and/or supplement providers in its networks or ensure members' access to care. In addition to the circumstances outlined in .07 B, CareFirst recommends adding the following circumstances:

- A carrier's maintenance of an open network to any licensed and practicing provider who can meet a carrier's credentialing requirements;
- A carrier's demonstration of its outreach to licensed and practicing providers to include them in the carrier's network;
- A carrier's use of telemedicine or telehealth to offer alternative provider availability to members;
- A carrier's efforts to assist members in identifying available licensed and practicing providers and obtaining appointments;
- A carrier's effort to limit members' cost sharing when seeing an out of network provider;
- A carrier's effort to ensure member access to care through alternative provider types (such as a nurse practitioner) and convenience care providers (such as MinuteClinic);

- A carrier's maintenance of a nurse advice line to aid members in determining the appropriate setting of care;
- A carrier's provision of financial incentives to providers to provide enhanced access to members via additional hours or days beyond the typical work week; and
- Other carrier activities undertaken to attract new providers or enhance or supplement its network.

Additionally, if the MIA decides to move forward with wait time standards, a waiver request requirement should be included for wait times as well. If a carrier can demonstrate outreach to providers reminding them of the wait times requirements that the provider must meet, whether through newsletters, phone calls, emails, written letters, surveys, or other mechanisms, then the carrier may request a waiver from the requirement.

Finally, section C (2) of the Waiver Request Requirements, which requires carriers who request a network adequacy waiver to submit a copy of the network adequacy waiver request form to providers, is inappropriate, unnecessary and burdensome. We strongly recommend that this requirement be removed from the draft.

We would be happy to discuss our recommendations with you and look forward to continuing this important work.

Sincerely,

Deborah R. Rivkin

Attachment

Deborah R. Rivkin
Vice President, Government Affairs - Maryland

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February 1, 2017

Nancy Grodin
Deputy Insurance Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Re: CareFirst Comments on HB 1318 Regulations

Dear Deputy Commissioner Grodin:

I write on behalf of CareFirst BlueCross BlueShield ("CareFirst") to provide CareFirst's recommendations to the Maryland Insurance Administration ("MIA") on the appropriate carrier network adequacy standards to be included in the MIA's forthcoming regulations required under HB 1318.

CareFirst has an extensive network of over 43,000 providers in its PPO network and over 38,000 providers in its HMO network. Given the breadth, depth, type and number of providers that participate with CareFirst, over 97% of all medical claims submitted by or on behalf of our members are paid to in-network providers. While only a very small percentage of our members seek services from out of network providers, it is important that the standards created for network adequacy are realistic and balance the needs of members to access providers with the efforts that carriers can take in managing their networks.

As detailed below, CareFirst encourages the MIA to establish network adequacy standards based on the model from Colorado, but not to accept wholesale the Colorado standard. CareFirst also strongly discourages the MIA from including appointment wait times in the network adequacy standards, as they are neither an accurate or appropriate measure of network adequacy, nor a measure within a carrier's control.

1. CareFirst Proposal for Geographic Access Standards for Maryland

CareFirst believes that having a consistent, clearly defined standard to determine the adequacy of carriers' provider networks should be established and that Colorado's geographic standards are informative and provide a framework upon which Maryland could build its network adequacy standards.

Colorado established provider availability requirements based on four different country specific distributions: large metropolitan regions, metropolitan regions, and micro regions and Counties with Extreme Access Considerations. CareFirst believes that different provider access requirements should apply to different density regions throughout the State. However, the Colorado geographic standards are unique to Colorado's geography

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and population and should be revised to reflect Maryland's distinctive geography, population, and provider distribution.

Based on our years of experience in analyzing access and licensed and practicing provider availability for our members, we propose dividing the State's geographic area into the following 3 categories to accurately reflect the unique population distributions within Maryland:

Region Type	**Population Density**
Urban	> 3000 per square mile
Suburban	1000 – 3000 per square mile
Rural	<1000 per square mile

The urban/rural classification is also consistent with how the Maryland Department of Planning consistently analyzes needs within the State.[1]

Within these geographies, we propose the following access standards for the three distinct region types given our extensive breadth and depth of experience in developing networks to best serve our members:

Provider Type	**Geographic Standard**
Primary Care Practitioners	**Urban**: 2 adult and 2 pediatric primary care providers ("PCPs") within 5 miles of the member's residence **Suburban:** 2 adult and 2 pediatric PCPs within 10 miles of the member's residence **Rural:** 2 adult and 2 pediatric PCPs within 20 miles of the member's residence
High-Volume and High-Impact Specialists[2]	**Urban:** 2 OB/GYN and 1 of each Orthopedic, Cardiology, Dermatology, Oncology, and Nephrology specialist within 5 miles of the member's residence 1 Psychiatrist within 8 miles of the member's residence **Suburban:** 2 OB/GYN and 1 of each Orthopedic, Cardiology, Dermatology, Oncology and Nephrology specialist within 10 miles of the member's residence 1 Psychiatrist within 18 miles of the member's residence **Rural:** 2 OB/GYN and 1 of each Orthopedic, Cardiology, Dermatology, Oncology, and Nephrology specialist within 30 miles of the member's residence 1 Psychiatrist within 45 miles of the member's residence
High Volume Behavioral Health Practitioners (measured for each category) – Psychiatrists, Licensed Professional Counselors	**Urban:** 1 behavioral health practitioner within 8 miles of the member's residence **Suburban:** 1 behavioral health practitioner within 18 miles of the member's residence

[1] See, for example, https://planning.maryland.gov/PDF/OurProducts/Publications/ModelsGuidelines/mg28.pdf.

[2] We have identified high-volume and high-impact providers based on our claims data. NCQA also defines high-impact specialists as those that provide care for conditions that result in high morbidity and mortality, or result in significant resource usage.

Provider Type	Geographic Standard
(Including Alcohol and Drug Counselors), Psychologists, Clinical Social Workers, Psych Nurses, Nurse Clinical Specialists	**Rural:** 1 behavioral health practitioner within 45 miles of the member's residence.

These standards strike the necessary balance for access, and are fully compliant with NCQA accreditation requirements.

Finally, CareFirst recommends that carriers should maintain these availability standards for 90% of their members, consistent with Colorado's standards. This percentage would reflect an exceedingly high probability that a member could seek necessary medical services within a reasonably close geography but still recognize that 100% adherence would be impossible for any carrier to meet, as providers move both in and out of network and move offices on a regular basis.

2. **Wait Times Are Not An Accurate Measure of Network Adequacy and Should Not Be Included in the MIA's Regulations**

We have a number of concerns with using provider wait times as a measure of network adequacy.

Wait times quoted to a member by a provider can differ based on a wide variety of factors not related to the size and breadth of a network, including but not limited to the following:

- Providers (not carriers) determine when to set appointments and office hours;
- Providers (not carriers) establish how many patients they wish to see during their office hours;
- Providers (not carriers) determine the urgency to see the provider based on the patient's type of medical condition and the condition's severity;
- Providers (not carriers) assess whether the requested visit is for a screening, for the treatment of a chronic condition, or for acute care;
- Providers may see a large variety of patients, including self-pay patients, Medicare and Medicaid patients, and patients who are members of other carriers and therefore do not reflect the adequacy of a given commercial carrier's network but the provider's entire universe of patients;
- Providers may not see patients on a regular basis in an office setting and therefore have longer wait times that are not reflective of network adequacy, because they teach, perform surgeries, conduct research or provide other types of services;
- Providers often practice in multiple locations, and so a wait time in one location is not indicative of a provider's availability elsewhere;
- Uniquely skilled providers (such as pediatric neurosurgeons) are not interchangeable with other providers, and so a long wait time to see a given provider is not indicative of a poor network nor recognizes the value and importance to members of having these highly skilled providers in network; and
- Provider wait times may vary throughout the year, such as where a pediatrician's office has a longer wait time at the end of summer and beginning of the school year.

Moreover, it would be operationally impossible for carriers to maintain accurate, up to date 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. Carriers cannot be expected to contact each of their participating providers on a recurring basis to determine their current wait times. To attempt to do so would be extremely costly. . Further, if wait times were required, reporting them annually or even quarterly would render them quickly meaningless as they change constantly.

CareFirst maintains that wait times are the same for a provider's entire universe of patients—a Medicare patient, Medicaid patient, private pay patient and a commercial carrier patient. Wait times are not specific or unique based on the type of insurance a patient has: they are, in fact, unique to each provider that is practicing in the state. Therefore, if wait times are to be meaningful, the provider, not the carrier should be required to report wait times to members/patients.

For these reasons, CareFirst strongly recommends against prescribed wait times as a measure of the adequacy of a carrier's network.

There are other tools available to assess whether wait times are an issue for members. CareFirst, like other health plans, uses the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to assess the total experience of its members, including a member's wait times to see providers. Monitoring plan performance using the CAHPS survey allows the comparison of performance of plans across product lines across carriers to better understand whether problems are broadly experienced by carriers in the State rather than a reflection of a particular carrier's network. Through the CAHPS survey, carriers directly ask enrollees if they have adequate access to care. This survey is the most widely used tool to gauge the consumer experience with their care and therefore is a valuable tool for the MIA to use to examine wait times in a network.

The CAHPS survey and member experience gauged in the survey is a far better tool to assist the MIA in measuring member access to care through a carrier's networks than the provider wait time standards that some stakeholders have sought during this hearing process. Instead, we propose the MIA use CAHPS survey results to examine members' experience with wait times and determine if those results identify issues with particular carriers.

3. Other Ways of Measuring Network Adequacy

At its heart, the debate over network adequacy is an attempt to ensure access to needed care for a carrier's members. CareFirst understands and takes very seriously carriers' obligations to ensure that their networks can meet their members' needs. However, we reiterate our previous testimony at the public hearings before the MIA and in writing that simply creating access standards does not create access. Carriers should not be subject to MIA enforcement action for things outside of their control.

Therefore, the MIA should deem the carrier's network adequate if the carrier can demonstrate evidence of its good faith efforts to enroll and/or supplement providers in its networks or ensure members' access to care.

Ways that a carrier's network could be deemed compliant despite a deficiency based on an adopted standard could include:

- A carrier's demonstration that there are an insufficient number of licensed and practicing providers in a given region to meet a given standard;
- A carrier's maintenance of an open network to any licensed and practicing provider who can meet a carrier's credentialing requirements;
- A carrier's demonstration of its outreach to licensed and practicing providers to include them in the carrier's network;
- A carrier's use of telemedicine or telehealth to offer alternative provider availability to members;
- A carrier's efforts to assist members in identifying available licensed and practicing providers and obtaining appointments;
- A carrier's effort to limit members' cost sharing when seeing an out of network provider;
- A carrier's effort to ensure member access to care through alternative provider types (such as a nurse practitioner) and convenience care providers (such as MinuteClinic);
- A carrier's maintenance of a nurse advice line to aid members in determining the appropriate setting of care;
- A carrier's provision of financial incentives to providers to provide enhanced access to members via additional hours or days beyond the typical work week; and
- Other carrier activities undertaken to attract new providers or enhance or supplement its network.

Demonstration of meeting this alternative standard ensures that a member has access to care, the goal of requiring network adequacy standards.

We would be happy to discuss our recommendations with you and look forward to continuing this important work.

Sincerely,

Deborah Rivkin