The
League
of
Life and
Health
Insurers
of
Maryland

200 Duke of Gloucester Street
Annapolis, Maryland 21401
410-269-1554

August 21, 2017

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

Re: Proposed Regulations 31.10.44 Network Adequacy

Dear Ms. Larson:

Thank you for the opportunity to provide comments on the Proposed Regulations 31.10.44 regarding Network Adequacy on behalf of the League of Life and Health Insurers of Maryland, Inc. (League). The League is the state trade association representing life and health insurance companies in Maryland. The League appreciates the work the Maryland Insurance Administration (MIA) has done on this issue from 2016 to date and also appreciates the collaborative process throughout.

The League would like to thank the MIA for its consideration of the comments submitted in May regarding the Draft Proposed Regulations on Network Adequacy. While the Proposed Regulations have addressed some of the questions and concerns we raised in our May letter, the Proposed Regulations still leave a number of concerns for League members.

One general comment to the overall Proposed Regulations is with respect to the omission of telehealth. Telehealth is an important mechanism for access to health care. Maryland has invested significant time creating a legislative framework for telehealth as a means to increase access to a variety of health care services in the state. As such, the League believes it is important that telehealth be incorporated in the Travel Distance Standards under the Proposed Regulation.

The League's specific concerns with and questions of the Proposed Regulations are as follows:

31.10.44.02 Definitions

31.10.44.02B.(16) "Primary care physician"
The Proposed Regulations define the term "Primary care physician" as a *physician* who is responsible for providing initial and primary care to patients; maintaining the continuity of patient care; or initiating referrals for specialist care (emphasis added). "Primary care

physician" includes a *physician* whose practice of medicine is limited to general practice and a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner. The League believes that the defined term should be changed to "Primary care provider" so as to be inclusive of certified registered nurse practitioners and other providers authorized to provide primary care.

31.10.44.02B(19) "Rural area", (21) "Suburban area", and (24) "Urban area"
The Proposed Regulations define "Rural area", "Suburban area", and "Urban area" as regions that, according to the Maryland Department of Planning have a human population of a certain level per square mile. The League has concerns about using data from the Department of Planning with respect to the method and manner in which the data are readily available to carriers. While carriers can typically use zip code level data, data provided in some other manner, such as census tract data, would be difficult for carriers to incorporate. The League recommends that these definitions be revised to incorporate zip code data.

31.10.44.02B(26) "Waiting time"
While the League appreciates the MIA's efforts at clarifying the definition of "Waiting time," this revised definition continues to raise concerns. The League believes that should wait times be used in the regulation, the "waiting time" for appointments that require prior authorization should not begin until after prior authorization has been granted. Current law already provides for timing relating to determinations for prior authorization requests. To combine the time for those determinations with the "waiting time" will result in a shorter time period for an enrollee or enrollee's treating provider to obtain an appointment for services requiring prior authorization.

31.10.44.04 Travel Distance Standards
With respect to the Sufficiency Standards and Group Model HMO Plans Sufficiency Standards, the League is uncertain as to what type of provider is included under "Other Provider Not Listed" and what type of facility is included in "Other Facilities." Carriers need clarity as to these categories so as to ensure compliance with this requirement and the League believes that providers and facilities subject to the standards should be listed. In addition, "Applied Behavioral Analysis" is neither a provider nor facility and should be stricken from the charts.

The League further recommends that the measure used for travel distance standards be changed to the percent of members who received care within the stated timeframe and recommends the threshold be the Medicare standard of 90% of members having access to a provider.

As indicated earlier, the standards should take into consideration access through telehealth. In addition, access through reciprocal networks in neighboring states, and other tools carriers use to provide access within the network to patients should also be considered. The regulations do not articulate how these and other approaches to access utilized by carriers will be considered as part of the travel distance standards. It is important that the MIA allow plans to make use of telehealth and other tools effectively and fully integrate these options into the Time and Distance Standards.

31.10.44.05 Appointment Waiting Time Standards

The League believes that wait times are not an appropriate quantitative standard for the entire Maryland market. Nationwide, less than a quarter of states use wait times as a network adequacy metric. While carriers endeavor to have a network with enough providers to minimize the time an enrollee must wait in order to access care, the measurement and enforcement of wait times is complex. Wait time standards assume there are adequate providers in a practice area or specialty such that, if a carrier contracts with the available, qualified and willing providers, the wait times are reasonable under the regulation. However, without a clear understanding of the provider supply in the state, it is difficult to determine if longer wait times are attributable to a lack of participating providers or a more general lack of available providers. This naturally varies by geography and specialty. The ability of a carrier to effectively manage wait times is also impacted by the delivery model. The relationship between a carrier operating a staff model HMO with a dedicated physician practice serving enrollees has far more influence over wait times and scheduling practices of providers than a more traditional PPO based delivery model. Traditional network models allow providers to control their office hours, scheduling practices, and patient mix. To impose specific wait time requirements assumes that carriers have control over these provider decisions, beyond contractual requirements included in provider contracts. Further, Maryland law already extends protections to patients who are unable to access an appointment without unreasonable travel or delay in a manner that allows the necessary case by case assessment each patients needs should warrant.

It is also unclear how this measure is to be assessed. Wait times may be sufficient over a broad category of services, yet still fall short for a particular patient at a particular moment in time. How will the MIA determine compliance across all providers for compliance reviews? The difficulty carriers experience with enforcement of wait times will also be a review challenge for the department.

The League recommends the Appointment Waiting Time Standards be stricken from the regulations, however, should these provisions remain, carriers are uncertain as to what services are included in, "Non-urgent ancillary services" as provided in the Chart of Waiting Time Standards and would request clarity on the types of services contemplated in this category.

31.10.44.06 Provider to Enrollee Ratio Standards

League members are unclear as to how the provider-to-enrollee ratio standards will be measured and requests clarity on these measures.

31.10.44.07 Waiver Request Requirements

It is well known that certain parts of the state lack certain types of facilities and providers. For example, Western Maryland has experienced a shortage of Obstetrician-Gynecologists for years. The League would like to request that the MIA deem that certain geographic areas of the State lack specific types of facilities and/or providers and that carriers need not file a waiver request for the areas and facilities or providers indicated. This practice would allow the MIA and carriers to focus efforts on improving access.

31.10.44.09 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. Instead,

we request that the standard be measured by the percent of members that have access to a stated provider type. This approach is consistent with the National Committee for Quality Assurance (NCQA) national standards that carriers are already collecting. To change to a different standard will be unnecessarily burdensome and difficult.

Thank you, again, for the opportunity to provide this feedback on the Proposed Regulations. Should you have any questions, please do not hesitate to contact me.

Very truly yours,

Tinna Damaso Quigley

Tinna Damaso Quigley, Esq.
Executive Director