July 19, 2021

Kathleen A. Birrane
Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202

Submitted to: networkadequacy.mia@maryland.gov

Dear Commissioner Birrane:

Thank you for the opportunity to submit comments on the use of telehealth to satisfy network adequacy requirements. These comments are submitted by the Legal Action Center and the undersigned members of the Maryland Parity Coalition. The Legal Action 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 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 standards and the recently-enacted Preserve Telehealth Act of 2021 (SB3/HB123) (hereafter "Preserve Telehealth" or SB 3).

Preserve Telehealth includes several provisions that relate directly to the use of telehealth to satisfy network adequacy requirements and, in our view, guide and set the parameters of the Maryland Insurance Administration's (MIA) regulatory options for the next two years. Current law permits carriers to use a telehealth appointment to satisfy appointment wait time metrics when it is clinically appropriate and the enrollee elects to use a telehealth appointment. COMAR § 31.10.44.05(A)(2). **We maintain that the "enrollee election" requirement must remain in place until June 30, 2023, at a minimum, to comply with Preserve Telehealth. It is also the appropriate standard to ensure that Marylanders have access to the most appropriate MH and SUD care as they face the greatest need ever for these health services.**

Enrollee election is necessary to ensure that carrier networks include a sufficient number of providers of in-person MH and SUD services – a predicate to enforcing the SB 3 provision that bars carriers from denying coverage or reimbursement of in-person MH or SUD services based solely on the availability of a telehealth service. *See* MD. CODE ANN., INS. § 15-139(c)(1)(iii). Retaining this standard is also necessary to ensure that the MIA can conduct a study of the impact of telehealth on the ability of consumers to choose in-person care as their service delivery mode. *See* Acts 2021, c. 70, § 3 and c. 71, § 3. While telehealth has been used extensively during the pandemic to deliver MH and SUD services, **post-public health emergency (PHE) claims data are needed to determine the rate at which patients continue to use telehealth and the appropriate mix of service delivery.** That data reflect the level of in-person MH and SUD services needed to ensure accessibility and availability of network providers. **Fundamentally, the MIA cannot measure this essential data point if enrollees lose their right to select the service delivery mode for MH and SUD care; telehealth services could readily become the**

predominate network option and leave no practical way to access in-person MH and SUD care that SB 3 protects, much less accurately measure the true need for in-person care.

I. Background

The COVID-19 pandemic has had a particularly harsh impact on individuals with MH and SUDs, resulting in an unprecedented number of overdose deaths, increased emergency department visits for suicidal ideation, and increased levels of anxiety and depression and demand for care. As Marylanders recover from the pandemic – which is not yet over – access to effective MH and SUD care is paramount. The appropriate mode of service delivery is unique to each individual and likely to change over the course of care. As multiple speakers noted during the MIA's June 18, 2021hearing, and as further discussed below, an individual's choice in how to receive MH and SUD care plays a critical role in determining how effective that course of treatment will be. For this reason, a critical issue in the SB 3 debate was the preservation of the right of consumers, in consultation with their provider, to choose the mode of service delivery for MH and SUD services – whether in-person, via telehealth or a hybrid model – to ensure that they would have access to the most appropriate care post-PHE.

To address this issue, the General Assembly adopted several protections:

- SB 3 preserves the right of patients with MH and SUDs to receive services in-person, by barring carriers from denying coverage for a covered behavioral health service "when provided in person solely because the behavioral health care services may also be provided through a covered telehealth benefit." MD. CODE ANN., INS. § 15-139(c)(1)(iii).
- SB 3 requires the MIA to study and report to the General Assembly by December 1, 2022, how telehealth can help "ensure health care provider network sufficiency" and the impact of telehealth "on the ability of consumers to choose in-person care versus telehealth care as the modality of receiving a covered service." Acts 2021, c. 70, § 3 and c. 71, § 3.

SB 3 also makes clear that the telehealth policies implemented during the during the PHE would remain in place until June 30, 2023, pending the General Assembly's consideration of the MIA and Maryland Health Care Commission's (MHCC) study and "adoption of comprehensive telehealth policies by the State." *See* Acts 2021, c. 70, § 4, c. 71, § 4. The intent was to preserve telehealth expansion and funding for two-years post-PHE in order to assess the role of telehealth in service delivery under non-pandemic conditions and allow for appropriate policy development.

Indeed, in addition to the MIA's specific inquiry into the relationship between telehealth and network adequacy, the MHCC is required to study the utilization of telehealth across different patient populations and health care conditions. The MHCC's study will help determine whether the increased utilization of telehealth for MH and SUD care during the pandemic will continue, the level of providers needed to meet the expanded need for MH and SUD services resulting from the pandemic, and the type of service delivery needed to meet MH and SUD patient needs.

These SB 3 standards govern any revision to the network adequacy regulations that contemplate the use of telehealth services to satisfy network adequacy metrics. We respectfully suggest that SB 3 limits the MIA's authority to remove the patient election requirement for wait time metric satisfaction until the end of the study period. It also limits the

adoption of a credit to the extent it would result in "satisfaction" of availability and accessibility standards that would otherwise trigger the enrollee's right, under Ins. § 15-830, to request services from a non-participating provider to obtain care within a reasonable time and distance.

II. Enrollee Election of Telehealth Appointment

As noted above, SB 3 bars carriers from denying in-person MH and SUD care solely because the service is available through telehealth service delivery. This means that enrollees have the right to **elect in-person service delivery** of MH and SUD services (or a hybrid of in-person and telehealth services) and that carriers must have a sufficient number of network providers to meet the in-person service delivery option. Maryland's existing telehealth standard is necessary to enforce this statutory right.

A. Rationale for Enrollee Election

Enrollee election is uniquely important for patients with MH and SUD conditions to ensure that care is clinically appropriate. Unlike many medical services, MH and SUD care centers primarily on talk therapy and does not inherently require an in-person examination or procedure (except as required by federal law for opioid treatment services and Schedule II Controlled Substance initiation). The MIA's proposed telehealth standard, which would allow a telehealth appointment to satisfy appointment wait time metrics if it is "clinically appropriate, available and accessible," will generally protect the right of patients with *non-behavioral health services* to get clinically appropriate services; the nature of the medical problem itself will largely dictate whether an in-person or telehealth appointment is clinically appropriate. **In contrast, for MH and SUD services, it is the patient's unique circumstances that sets the parameters of "clinical appropriateness," and "enrollee election" is essentially the proxy for a medical procedure that requires in-person care.** The patient and their behavioral health practitioner determine whether telehealth is clinically appropriate; even though the required service may theoretically be delivered via telehealth, a telehealth visit may be ***clinically inappropriate*** for a patient.

The MIA's first question (i.e. the reasons that enrollee preference must be taken into account for telehealth as opposed to in-person services) speaks to the individualized circumstances of the patient seeking MH and SUD care. In contrast to in-person services, telehealth may not provide the degree of privacy or "safe haven" that is required therapeutically for some patients. Second, some patients, including children and adolescents, experience a level of distractibility and inability to forge a therapeutic relationship during a telehealth appointment, which renders the care non-therapeutic. Third, many patients need a communal setting to counter isolation that contribute to the resumption of substance use and decline in mental health and well-being. Finally, the level of acuity differs dramatically across patients, particularly as many have received care virtually during the pandemic, and, based on the patient's diagnosis, a telehealth visit will not meet therapeutic needs.

The carrier's objection to the consumer election requirement as "unreasonable" misses this essential clinical difference between behavioral and somatic care. The elimination of enrollee election would remove the guardrail that helps ensure clinical appropriateness of MH and SUD services. **We suggest that the failure of carriers to credential a sufficient number of MH and SUD providers leads to pressure to adopt an expansive telehealth standard that will undermine the availability of clinically appropriate care for these patients.** For example, during the pandemic, many children and adolescents had access to behavioral health counseling via telehealth but could not participate in a meaningful way. Undoubtedly, those families will

elect to have in-person services, and SB 3 gives them the right to that clinically appropriate care.

A second objection posed by the carriers to enrollee election is the difficulty in operationalizing this standard for metric satisfaction. This objection is belied by two carriers – CareFirst and Kaiser Permanente – that reported, in 2019, their use of telehealth to satisfy appointment wait time. The extensive data presented by Kaiser Permanente at the MIA's June 18th hearing also demonstrate the carrier's ability to track utilization of telehealth services in great detail. Pre-pandemic, carriers likely relied on claims data, which contain modifiers for telehealth services, to estimate telehealth utilization for the wait time metric. Going forward, if the enrollee election requirement is preserved, carriers will operationalize and report it in the same way; i.e. through claims data analysis. **Claims data will be a key indicator of enrollee "choice" for MH and SUD service delivery and helpful to inform the MIA's study.** And, to ascertain the availability of a MH or SUD appointment prospectively, as proposed in the MIA draft proposed rule, a question could be posed that seeks information on both in-person and telehealth appointments for varying levels of MH and SUD care.

B. State Protection of Access to In-Person Care

A handful of states have developed standards to regulate the use of telehealth services for purposes of network adequacy. **Importantly, they all establish standards that protect the consumer's right to access in-person services.** We have identified the following state standards through a 50-state survey.

- Two states – Arizona[1] and Colorado[2] – allow telehealth services to be used to deliver covered services, but both require carriers to provide adequate access to in-person health services. Arizona also explicitly prohibits satisfaction of network adequacy standards through the use of a contracted care provider that provides telehealth services alone and does not offer in-person services within the state or within 50 miles of the state's border. Colorado's telehealth provision states that "the availability of telehealth services does not modify the requirements imposed on carriers under [§ 10-16-704 network adequacy requirements] to provide a sufficient network of providers available in the community to provide in-person health care services."

- Three state – Maine,[3] Massachusetts[4] and Oregon[5] – either bar reliance on telehealth services for satisfaction of network adequacy requirements or impose other limitations on consideration of telehealth for network adequacy purposes. Maine and Oregon prohibit carriers from using telehealth to demonstrate adequacy of their networks. Massachusetts prohibits insurers from "meet[ing] network adequacy through significant reliance on telehealth providers" and insurers "shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner upon request."

[1] ARIZ. REV. STAT. § 20-1057.13.

[2] COLO. REV. STAT. §10-16-123(2)(b)(III).

[3] ME. REV. STAT. ANN. tit. 24-A, § 4316.

[4] MASS. GEN. LAWS ANN. ch. 176G, § 33; MASS. GEN. LAWS ANN. ch. 32A, § 30; MASS. GEN. LAWS ANN. ch. 118E, § 79; and MASS. GEN. LAWS ANN. ch. 175, § 47MM.

[5] OR. REV. STAT. ANN. § 743A.058.

- Two states – Minnesota[6] and New Hampshire[7] – only permit consideration of telehealth service availability in a request to waive network adequacy standards based on the unavailability of providers of in-person services. Both states apply this standard for geographic accessibility standards, and New Hampshire requires the telehealth service to be provided by an in-network participating provider.

SB 3 affords Marylanders seeking MH and SUD services the same protections as individuals in the above states. **Removal of the enrollee election requirement will conflict with statutory protections that remain in place for at least the next two years.**

Finally, to ensure collection of useful data for future policy development, retention of the existing standard is essential to evaluate the impact of telehealth on access to in-person MH and SUD services. **Enrollee election is the operative standard pending any revision of the network adequacy regulations.** Should the MIA remove this requirement, a true assessment of consumer preference **cannot be measured if consumers no longer have a choice of electing in-person or telehealth services.** Depending on the timing of the MIA's study and promulgation of the revised network adequacy regulations, carrier claims data could reflect enrollee care decisions based on two different standards. The failure to hold this variable constant will undermine the value of the data in tracking post-PHE telehealth utilization trends.

III. Credit for the Delivery of Telehealth Services

We similarly oppose the carrier's recommendation to adopt a credit to satisfy either the geographical or appointment wait time metric based on the availability of telehealth services, as under Medicare Advantage. The Medicare credit model, which has been implemented for the first time in 2021, applies to a subset of providers and geographical regions[8] and is untested. No data have been collected to determine if this standard is effective, let alone how it is working, nor has any other state adopted this model. As proposed by the carriers, the credit is insufficient to protect Marylanders seeking MH and SUD services who, under SB 3, cannot be denied in-person services based on the availability of a telehealth service. Importantly, the carriers fail to acknowledge that, even under the Medicare model, a Medicare Advantage plan **cannot count these additional telehealth benefits as basic benefits covered under original Medicare** (as opposed to a supplemental benefit) unless they:

> (1) "[f]urnish in-person access to the specific Part B service(s) at the election of the enrollee [and]
>
> (2) [a]dvise each enrollee that the enrollee may receive the specified Part B service(s) through an in-person visit or through electronic exchange…"

42 C.F.R. **§** 422.135(b) and (c). In adopting the credit, the Centers for Medicare and Medicaid Services noted that "this protection preserves a beneficiary's right to choose when they would prefer to have medically necessary care provided in-person rather than through electronic

[6] MINN. STAT. ANN. § 62K.10.

[7] N.H. CODE ADMIN. R. ANN. INS. § 2701.08.

[8] Absent a PHE, Medicare reimburses telehealth services when the originating site is in a geographical area that is designated as a rural health professional shortage area or in a county that is not included in a Metropolitan Statistical Area. 42 U.S.C. § 1395m(m)(4)(C)(i). The geographical restriction does not apply to the delivery of SUD services. 42 U.S.C. § 1395(m)(m)(7).

exchange."[9] Clearly, Medicare has adopted the very protection preserved under SB 3 for enrollees seeking MH and SUD services.

The application of a credit for both appointment wait time and geographical distance standards, as requested by at least one carrier, could also undermine a consumer's right under Ins. § 15-830 to request approval to receive services from a non-participating provider if in-network providers (or services) are not available within a reasonable time and distance. SB 3 did not amend this statutory right. Yet creating a telehealth credit that would satisfy both metrics extinguishes the right without providing true access to appropriate care. Carriers would have even less incentive to credential MH or SUD providers who will deliver in-person services.

If a credit were considered for ***non-behavioral health services***, we agree with the MIA's observation that additional requirements must be imposed to ensure that a telehealth appointment is available and accessible. Carriers must ensure that an enrollee has the technology and broadband connectivity to use telehealth services within each zip code area and that enrollees are both aware of their right and have the capacity to identify and select providers outside their geographical region. A carrier should not be able to claim a credit for enrollees who lack access to broadband and for whom an audio-only call is not appropriate for medical care. Additionally, because SB 3 prohibits a carrier from requiring that a covered service be delivered through a designated third-party telehealth vendor (MD. CODE ANN., INS. § 15-139(e)), a carrier should also be required to demonstrate that its network has a range of providers for covered services.

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We appreciate the MIA's thoughtful process for improving enforcement of the network adequacy requirements. We urge you to move forward with proposed regulatory revisions that permit telehealth services to be counted for appointment wait time satisfaction if they are clinically appropriate, available and accessible and, for purpose for MH and SUD services, elected by the enrollee. Thank you for considering our views.

Sincerely,

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Maryland Addiction Directors Council
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[9] Centers for Medicare & Medicaid Services, *Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program*, 85 Fed. Reg. 33796, 33863 (June 2, 2020), https://www.govinfo.gov/content/pkg/FR-2020-06-02/pdf/2020-11342.pdf.