March 27, 2023

Lisa Larson
Director of Hearings
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202

RE: Notice of Proposed Action, 22-368-P, Network Adequacy 31.10.44

Dear Ms. Larson,

The Legal Action Center and the sixteen undersigned organizations that participate in the Maryland Parity Coalition appreciate the opportunity to submit comments on the Maryland Insurance Administration's (MIA) proposed rule on network adequacy standards, § 31.10.44. The Legal Action Center (LAC) is a non-profit organization that uses legal and policy strategies to fight discrimination against individuals with substance use disorders, arrest and conviction records, and HIV or AIDS and to build health equity and restore opportunities for these individuals. LAC was actively involved in the development of the current network adequacy standards, has monitored carrier compliance with those metrics and has submitted extensive comments on previous drafts of the proposed regulation. LAC also convenes and chairs the Maryland Parity Coalition, which has worked for many years to ensure adequate and accessible provider networks for individuals with substance use disorders and mental health conditions. With the increased use of telehealth, the Parity Coalition has also advocated for protections that allow consumers, in consultation with their providers, to choose the mode of service delivery that meets their health needs.

We appreciate the MIA's careful consideration of LAC's recommendations over the course of the development of the proposed network adequacy regulations which have focused on requiring carrier reporting of:

- substance use disorder (SUD) and mental health (MH) practitioners and facilities and services with greater granularity in the travel distance and appointment wait time metrics;
- coverage and availability of **in-person** SUD and MH services to ensure that Marylanders can effectively exercise their choice to see a practitioner in-person, via telehealth or a combination of both;
- carrier contracting efforts when network metrics have not been satisfied; and
- all metrics through standardized definitions, methodologies and templates.

As detailed below, we support the MIA's proposed rules that address these issues in large part. We do request revisions to clarify the carrier's obligation to submit waiver information, under 31.10.44.09, if it fails to meet metrics based on provider availability of in-person services and without consideration of the proposed telehealth credit. We also continue to oppose the adoption

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of a telehealth credit pending additional data gathering and analysis of carrier practices to deliver in-person services, consistent with the proposed rule, and telehealth utilization. **We suggest that delayed adoption of the telehealth credit is most consistent with the anticipated two-year extension and study of audio-only telehealth and payment parity requirements (*see* SB 534) and with recommendations from the U.S. Department of Health and Human Services regarding telehealth for qualified health plans.**[1]

We also support the adoption of the proposed regulations that will require carriers to submit, as part of their access plans, critically important and detailed data on network coverage of SUD and MH providers that deliver in-person services, out-of-network provider utilization, requests for and use of single-case agreements, and the inclusion of practitioners that meet the health needs of Marylanders across racial, ethnic, gender, sexual orientation, gender identity and disability. As recommended in previous comments and below, **we urge the MIA to make this information available to the General Assembly in aggregate data reports and through briefings to inform policy development and ensure transparency for both the public and employers who seek accessible MH and SUD for their workforce.** We learned a tremendous amount about the MIA's network adequacy data collection efforts and carrier telehealth practices via the MIA's report required under by the Preserve Telehealth Access Act of 2021.[2] This serves as an excellent model for regular network adequacy updates and is essential to comprehensive policy development.

I. Definitions – 31.10.44.02

We support the proposed definitions and specifically appreciate the inclusion of the term "opioid treatment services provider" to allow for the tracking of these critical services in the travel distance metric. We also appreciate the clarification of services covered under "residential crisis services." Finally, the definition of "road travel distance" will lend greater uniformity to data reporting across carriers.

II. Network Adequacy Standards – 31.10.44.03

Over the course of the development of the network adequacy rule, components of the proposed standards have been both strengthened and weakened. We recommend the following revisions to improve oversight of carrier practices.

First, regarding the "count" of providers in a carrier's network, (.03(A)(7)), the proposed rule would require carriers to "have the ability to identify" the number of participating providers listed in the uniform credentialing form and facilities identified in the travel distance chart under .05A(5) and B(5). **While we support the inclusion of facilities as well as practitioners in that count to ensure comprehensive data, we urge the MIA to require the carriers to *identify that count* rather than "have the ability" to do so.** We urge the MIA to use the language in its 2022 draft proposal for this purpose, revising the language to read:

> A carrier **shall identify** by county and for the City of Baltimore, the number of participating providers for each facility type listed in the charts in Regulation .05(A)5) and B(5) of this chapter and each provider type code and specialty code listed on the

[1] Dept. of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023," 87 Fed. Reg. 27208, 27333 (Final Rule May 6, 2022).
[2] NORC, Technical Report of the Maryland Telehealth Study, The Maryland Insurance Administration (MIA) Report, App. I (Oct. 28, 2022) (hereafter MIA Report).
https://mhcc.maryland.gov/mhcc/pages/hit/hit_telemedicine/documents/hit_norc_technical_rpt.pdf.

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uniform credentialing form described in Insurance Article, § 15-112.1, Annotated Code of Maryland.

Second, while we support the requirement that carriers conduct internal audits on at least a quarterly basis, (.03(B)), we **urge the MIA to develop a standardized form for such audits and require that carriers make those audits available to the MIA on request and affirm that quarterly audits have been conducted.**

Finally, the rule would appropriately require carriers to have network providers that meet accessibility requirements for individuals with physical or mental disabilities and deliver culturally competent services. (.03(A)(4) and (5)). Yet the standard – "reasonable steps to ensure" – is not defined and will invariably result in subjective decision-making and enforcement problems. As much of the carrier information on its efforts will be included in their non-public access plans, it is important for external stakeholders to have basic information about carrier network coverage in these areas to assess compliance with the regulations. Given the disproportionate impact of the opioid overdose crisis on communities of colore, especially Black Marylanders, we believe it is necessary to clearly define and publicize this access information. **We urge the MIA to make aggregate data on carrier efforts to meet accessibility requirements and deliver culturally competent services available to the General Assembly and public stakeholders for this purpose.**

III. Filing and Content of Access Plans – 31.10.44.04

We support the proposed data points and procedures that carriers must submit annually in their access plan and urge the MIA to retain all elements. We are particularly supportive of data reporting requirements on out-of-network utilization and amounts billed and paid, single-case agreements and complaints related to a range of network issues. We appreciate the inclusion of a data point for the number of single-case agreements that have been requested, under (04(C)(3)(e)(v), in addition to other data on such agreements. **As noted above, the submission of annual reports to the General Assembly that summarize key trends is essential to ensure transparency and improve access to network services.**

We are aware that the MIA is not required to submit forms as part of the rule-making process, **but we reiterate our recommendation that the MIA develop uniform definitions, methodologies and report templates for all requested data and require, in the regulations, that carriers submit such information using forms posted on the MIA's website.**

IV. Travel Distance Standards – 31.10.44.05

We support the proposed travel distance standards and the level of granularity for tracking the full range of MH and SUD providers and facilities: addiction medicine; licensed professional counselors; psychiatry separately reported for adolescent and child, geriatric and other outpatient services; inpatient psychiatric facility; opioid treatment service provider; outpatient mental health clinic; outpatient substance use disorder facility; residential crisis services; and substance use disorder residential treatment facility. Tracking the inclusion of "opioid treatment service provider" separately from "outpatient substance use disorder facilities" will identify network gaps for essential providers of medication for opioid use disorder, which is necessary to address Maryland's overdose epidemic.

We also support the detailed descriptions of the methodologies that carriers may use to track to satisfaction of the travel distance metric. **We urge the MIA to achieve this same level of detail in addressing the surveys that are required for reporting compliance with the appointment wait time metric.**

Finally, we support the proposed essential community provider standard, which will result in more extensive inclusion of community-based SUD and MH providers.

V. Appointment Waiting Time Standards – 31.10.44.06

We support the proposed appointment waiting time standards insofar as they would:

- require documentation of in-person service availability,
- provide far greater granularity for determining the availability of MH and SUD services by separately reporting inpatient urgent care, outpatient urgent care and non-urgent care for MH, SUD and medical services, and
- require carriers to conduct a review on a semiannual basis and notify the MIA within ten days of identifying a deficiency for in-person appointments.

These standards should allow for more timely identification of service gaps and corrective action by the MIA.

We are deeply concerned, however, about the proposed standard for gathering appointment wait time data. This metric is the most important measure of a member's access to timely care, and the MIA's proposed standard for the carrier-conducted survey does not provide sufficient detail or precision to ensure usable and consistent data across all carriers. **We do, however, support the proposal for the MIA to conduct a centralized survey, as this approach would result in more complete and consistent data across all carriers.**

The MIA's proposed survey, in contrast to the proposed carrier-conducted survey, would be required to use a "statistically reliable and valid methodology" for contacting a random selection of providers, and the MIA would be required to publish the survey methodology. (.06(A)(5)(a) and (c)). The proposed carrier-conducted survey standards provide no methodology for the "random selection" of providers, no requirement for the carrier to identify its methodology – much less conform to a statistically reliable and valid approach – and offer no guidance to define the providers who are "qualified" for each service. We anticipate that each carrier will define the pool of "qualified" providers in a different way – including counting providers who are not specialized MH and SUD providers and do not possess the professional training and expertise" to treat those conditions as required by law for satisfaction of provider panel requirements. (Ins. § 15-830(d)). As with the existing regulatory standards, the absence of standardized definitions and methodologies in regulation and a standardized template will result in inconsistent and incomparable data and will undermine enforcement. **We, therefore, urge the MIA to adopt the MIA centralized survey as the singular method for evaluating appointment waiting times and remove the carrier-conducted survey process from the regulation.** This would also ease the carrier's burden and, more important, help providers who generally participate in multiple insurance plans and, thus, could be selected to participate in multiple surveys by each carrier.

If the MIA retains the carrier-conducted survey, we urge the inclusion of the standards that would govern the development of the MIA's centralized survey, as identified above, and require carriers to use the same methodology and data gathering templates. Additionally, with the proposed removal of the member survey as one component of the calculation, the carrier will not

be required to assess the availability of practitioners who possess the skill and expertise to treat a range of MH and SUD conditions. **This precludes a complete assessment of whether the carrier's network meets statutory standards and must be incorporated back into the standard. We would similarly request that the MIA's centralized survey include a component that evaluates whether members have access to providers with the requisite skill and expertise.**

VI. Telehealth – 31.10.44.08

We agree that telehealth should be counted for satisfaction of travel distance and appointment waiting time metrics ***provided*** the carrier demonstrates that telehealth is clinically appropriate, available, accessible and elected by the member. **We appreciate and support the MIA's clarification of standards related to a member's right to receive in-person services and strengthened regulatory requirements for carriers to demonstrate the coverage of a comparable in-person appointment should the member elect that delivery mode and procedures to assist a member in accessing an in-person appointment in a timely manner. (.08(C)(3)(b) and (D)(2)).** These provisions should be adopted without regard to the use of a telehealth credit.

We continue to believe that it is premature to adopt a telehealth credit to satisfy network adequacy standards. The MIA explained in its 2022 telehealth report, submitted as part of the Maryland Health Care Commission's telehealth study, that the goal of adopting a telehealth credit is to incentivize carriers to improve access to telehealth services, obtain more comprehensive and accurate data and leverage telehealth to support network adequacy efforts.[3] Yet, there is no evidence that carriers will abandon or do anything other than expand telehealth services post-pandemic. Indeed, national carriers have developed nationwide telehealth networks to make services – particularly mental health and substance use care – more widely available.[4] Under these circumstances, a credit is not needed as a proxy for the actual utilization of telehealth service delivery, which can be tracked through a combination of claims data, enrollee surveys and other tools identified by the MIA in .08(D). **While carriers may have chosen to not develop tools to track and report their enrollees' use of telehealth pre-pandemic, the proposed rule would require submission of significant telehealth data that will require carriers to track their utilization of those services and allow them to claim credit.**

If, however, the MIA adopts the proposed credit, **we urge you to address the technical issue outlined below and set a future effective date of July 2025 for the two telehealth credits.** This timeline will allow carriers to submit post-pandemic telehealth utilization and claims data, which, under .08(A)(1), will not be required until July 1, 2024 at the earliest, and to compile the substantial body of information that would be required to support a request for the appointment wait time and travel distance credit. **The MIA could also encourage interested carriers to submit this information on a provisional basis, prior to the future effective date, so that it can assess telehealth utilization and whether its credit standards are the right ones.** We know of no other state that has adopted a telehealth credit for purposes of satisfying network adequacy and, indeed, several states explicitly bar or restrict reliance on telehealth services to satisfy network adequacy.[5] The credit remains untested outside of the Medicare Advantage

[3] MIA Report *supra* note 1 at 149-150.
[4] The MIA reported that one national carrier that offers plans in Maryland has a telehealth network of "over 5500 telehealth only providers in the behavioral health category." *Id*. at 133.
[5] *See*, ME. REV. STAT. ANN. Tit. 24-A § 4316 (10) (2021) (bars use of telehealth to demonstrate adequacy of network); MASS. GEN. LAWS ch 175 § 47MM(b) (2020) (insurer shall not meet network adequacy through significant reliance on telehealth providers and shall not be considered to have an adequate network if patients are

context, which only permits a travel time and distance credit and for additional telehealth benefits. Furthermore, the U.S. Department of Health and Human Services decided to not apply the Medicare Advantage telehealth credit to private insurance plans on the basis that "more research is needed," further asserting that "telehealth services should be made available in addition to, rather than instead of, in-person care."[6]

A testing period will also help address an outstanding technical question regarding the appointment wait time credit. As noted in our 2022 draft proposal comments, the proposed rule would allow carriers to request a credit of up to 10% for each service category in which the metric has not been met, but it **offers no criteria for identifying the appropriate percentage value based on an objective assessment of how a credit should apply to each service type.** We would expect the carrier to seek the full 10% credit even if the availability and use of telehealth services vary dramatically for the different types of services. While the MIA would have to approve the credit and could presumably lower the percentage value awarded, criteria are needed to ensure transparency and consistent application across carriers. **We urge the MIA to develop and share such criteria before the adoption of the telehealth credit.**

VII. Network Adequacy Waiver Standards – 31.10.44.09

We support the proposed standards that would require a carrier to submit detailed information about efforts to contract with providers when it fails to meet one or more standards specified in .05 – .07. and to require the MIA to post any waiver that has been granted. We note, however, that the revised standard would make the carrier's information available only in its access plan and, thus, remove the underlying request and supporting information from public view, as required in the existing regulation. **Such information is critically important to assess the underlying factors that contribute to inadequate networks and, like other information contained in access plans, must be made available to policymakers and stakeholders in the form of aggregate data reports.**

Additionally, we urge the MIA to clarify in .09 that a waiver must be submitted if the carrier does not satisfy the standards in .05-.07 ***without the use of the telehealth credit*** (if and when adopted). We urge the inclusion of the following language in .09(A) to clarify this standard.

> If a carrier's provider panel fails to meet one or more of the standards specified in Regulations .05-.07 of this chapter **for in-person services and without consideration of the telehealth credit specified in Regulation .08 of this chapter,** the carrier shall provide the following information to the Commissioner as part of the annual access plan.

VIII. Network Access Plan Executive Summary Form – 31.10.44.10

We support the proposed standards related to the content of the summary form for travel distance and provider-enrollee ratios. For the appointment wait time content, **we support the clarification that the median wait time is calculated for an in-person visit and does not include telehealth appointments. Additionally, as noted in our 2022 draft proposed comments, we urge the MIA to include the required wait time metric for each of the service categories and require carriers to provide data on the percentage of appointments that are satisfied for each service category, as in the existing standard.** The general public will not know where to access the wait time metric and should not be left in the dark as to whether their

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not able to access appropriate in-person services in a timely manner upon request); OR. REV. STAT. 743A.058(5)(c) (2021) (bars use of telehealth services to demonstrate network adequacy).

[6] HHS Rule *supra* note 1 at 27333.

carrier meets the regulatory requirement. The satisfaction rate will be made publicly available for the travel distance metric and should similarly be available for appointment wait time.

We appreciate the proposed revision to the telehealth-related statements that carriers may include in their summary form. **We remain concerned that carriers will be including information in the form that is related to the use of a telehealth credit prior to any determination that they are entitled to an appointment wait time credit.** We, therefore, urge the MIA to clarify that the statement should not be associated with any category of service or for any specific metric. We suggest the following stand-alone statement.

> **Telehealth appointments may be available to supplement in-person services that must be available within a reasonable travel distance and appointment wait time.**

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Thank you for considering our views.

Please contact Ellen Weber (eweber@lac.org) with any questions.

AHEC West
Community Behavioral Health Association of Maryland
Institutes for Behavior Resources, Inc.
James' Place Inc.
Maryland Association for the Treatment of Opioid Dependence
Maryland Addiction Directors Council (MADC)
Maryland Coalition of Families
Maryland Psychiatric Society
Maryland Psychological Association
Mental Health Association of Maryland
Montgomery County Council of Parent Teacher Associations
Montgomery County Federation of Families for Children's Mental Health, Inc.
National Multiple Sclerosis Society
NAMI Maryland
National Council on Alcoholism and Drug Dependence-Maryland (NCADD-Maryland)
Voices of Hope, Inc.