



Maryland
Hospital Association

August 11, 2022

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

Emailed to: InsuranceRegReview.MIA@maryland.gov

Re: Draft Network Adequacy Regulations – July/August 2022

Dear Ms. Larson:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on the Maryland Insurance Administration's (MIA) draft revisions to the Maryland Network Adequacy regulations at COMAR 31.10.44. MHA commends MIA for proposing standards that give meaningful information to providers and consumers on network coverage. The following emphasizes our suggestions for provisions that resonate with MHA's priority issues.

Behavioral Health Care Access

Maryland hospitals occupy a unique position within the behavioral health continuum of care. Emergency departments are sometimes the first point of contact for individuals with behavioral health disorders; however, they need a full care continuum. Discharged patients must have immediate access to community behavioral health providers, or step-down programs, within their insurance networks. Without a robust network, patients—especially children and adolescents—are forced to board in hospitals for months at a time, which exacerbates their existing conditions.

We appreciate additional behavioral health specialties being included in the wait time and travel distance standards. We recommend revisiting those standards to measure carrier compliance and access. Additionally, we urge MIA to publicize the percent of out-of-network utilization from their members for behavioral health services, stratified by ZIP code. This could help hospitals discharge patients to appropriate step-down facilities, while also identifying areas of significant in-network provider shortages.

We also support MIA's proposal to require carriers to describe their incentives, such as educational loan repayment, for providers from diverse cultural, racial, or ethnic backgrounds.

Telehealth

We appreciate MIA’s expanded telehealth data reporting and support the proposal to align the definition of telehealth with Insurance, § 15-139. Many patients continue to prefer telehealth care, and it is important to document uptake for future efforts to expand access to necessary care.

Determining clinical appropriateness

MHA supports using “clinical appropriateness” to determine whether telehealth is the right delivery mode for a particular service. However, as currently constructed in the regulation, the determination of clinical appropriateness lacks any connection to patient choice. The treating provider is best suited to identify whether the patient’s clinical condition can be addressed via telehealth and, in consultation with the patient, if a telehealth visit can meet the patient’s needs. Onerous upfront utilization management requirements around establishing clinical appropriateness detracts from the primary focus of telehealth, which is patient care at the right place, time, and level, and may result in missed or skipped visits altogether. We encourage MIA to require carriers to include their policies and criteria regarding the clinical appropriateness of an offered telehealth visit, especially around any requirements placed on providers to prove the clinical appropriateness of a telehealth visit.

Defining “available and accessible”

MIA uses the phrase “available and accessible” to describe how telehealth services should be offered to enrollees but does not define these terms. MIA should define this phrase to ensure clarity and to make clear the importance of patient choice—in addition to provider judgment—when determining whether a service may be delivered via telehealth. The definition should consider:

- Desired time frame for an appointment
- Consent to the telehealth appointment in lieu of an in-person visit
- Approval of the modality used to deliver the service (e.g., synchronous audio-visual telecommunication, audio-only, etc.)

We also recommend MIA use the phrase “clinically appropriate, available, and accessible” when describing telehealth services to ensure consistency throughout the regulations.

Out-of-state telehealth providers

Telehealth’s portability is one of its most attractive features. MHA supports using out-of-state practitioners when necessary to supplement provider shortages. However, we are concerned carriers will use national telehealth providers in lieu of building their network of local providers who offer both in-person and telehealth services. This discourages the development of a robust network of Maryland providers, which is detrimental to efficient and effective patient care, especially as hybrid treatment plans (i.e., both in-person and telehealth visits with the same provider) become more common. Additionally, this practice results in Marylanders losing in-network coverage to locally available services in favor of providers unfamiliar with available care resources in the state.

MIA should require carriers to share:

- Percentage of enrollees who are referred out-of-state for telehealth visits
- Types of visits referred out-of-state for telehealth
- Geographic data (e.g., state, ZIP code) for telehealth providers to whom they refer their enrollees to confirm compliance with state licensure compacts

Thank you for considering our views and recommendations. We look forward to working with MIA and all stakeholders throughout the regulatory process. Please do not hesitate to reach out to Diana Hsu (dhsu@mhaonline.org) with any questions.

Sincerely,



Erin M. Dorrien
Vice President, Policy

CC: David Cooney, Associate Commissioner