Deborah Rivkin
Vice President
Government Affairs – Maryland

CareFirst BlueCross BlueShield
1501 S. Clinton Street, Suite 700
Baltimore, MD 21224-5744
Tel. 410-528-7054
Fax 410-528-7981

Sent via email: **insuranceregreview.mia@maryland.gov**

December 4, 2020

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

Dear Ms. Larson:

CareFirst BlueCross BlueShield (CareFirst) appreciates the opportunity to provide formal comments on the Maryland Insurance Administration's (MIA) Draft Proposed Network Adequacy Regulations (COMAR 31.10.44). We offer general feedback for your consideration below. Additionally, attached, we have noted specific technical and substantive issues of concern and offer proposed alternatives using the comments feature in Word. We also suggest edits to address minor technical issues in the regulations using tracked changes.

CareFirst continues to be supportive of the MIA's policy goal of making sure that the services covered in our contracts are readily available and accessible to our members; however, the regulations as proposed require burdensome and in many cases unattainable data audits with no guarantee that these efforts will in fact, further our shared goal of network adequacy.

CareFirst is committed to being a good faith partner to the MIA in this effort and is prepared to explore, propose, and discuss viable alternative policy options to these draft regulations. We look forward to discussing these regulations in further detail with the MIA, and to actively participating in forthcoming meetings with all stakeholders in our shared effort to achieve meaningful regulatory oversight that can be reasonably implemented.

General Observations

(1) Monthly Internal Compliance Audits

Regulation .03B requires that carriers monitor our networks for compliance with this entire Chapter of regulations on at least a monthly basis. This goes beyond the statutory requirement that we monitor our networks on "an ongoing basis," and requires a monthly audit of each provision in these regulations, even for content that does not regularly change or for which we have no reason to believe adequacy is threatened.

CareFirst is constantly monitoring our networks for adequacy, and proactively seeks to maintain and enhance our networks where the greatest needs exist. A monthly audit for its own sake diverts carrier resources to items of little concern, creating unnecessary work and expense with limited value added.

(2) New Monthly, Quarterly, and Annual Administrative Requirements on Carriers, Providers, and Members

These regulations contain numerous new provisions, outlined at the end of this letter, that require carriers to survey providers and members on a variety of issues during variable prescribed timeframes (monthly, quarterly, annually). We comment on each in the attached document. In totality, these provisions impose significant administrative requirements that go beyond what is reasonable, practical, or useful in measuring whether consumers have adequate access to care. From a staffing, administrative, and financial perspective, the totality of these requirements is far more expansive than what exists today and what we see around the country. These requirements literally reimagine how carriers monitor network adequacy compliance in Maryland. Further, as discussed in the attached, we question the value that some of these provisions would provide to the MIA in ensuring compliance with network adequacy standards.

Carriers monitor network compliance on an ongoing basis as required by statute. Rather than imposing this breadth of new, burdensome, untested audit requirements on carriers, providers, and members, we recommend that the MIA explore the proposed alternative regulatory solutions that we reference in the attached to measure network adequacy. We believe that there are far more efficient ways for carriers to demonstrate their ongoing compliance efforts.

(3) Expanding Authority over Providers

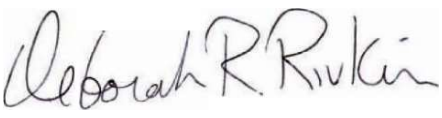
These regulations add many provisions requiring carriers to elicit information from providers that the MIA currently lacks the statutory authority to itself request. The MIA should explore whether legislation to expand its authority over providers for information concerning the provision of appropriate access and care to consumers, or legislation to expand Board level oversight of providers with respect to the provision of appropriate access and care to consumers, is a more efficient and accurate way to obtain specified information.

(4) Uniform Credentialing Form

Several new data points requested in these regulations are not part of the MIA's Uniform Credentialing Form. Rather than creating new reporting requirements that can only be obtained through various carrier surveys of providers, the MIA should consider enhancing its Uniform Credentialing Form to include specified points of interest from providers. This application is one of the few tools that the MIA presently has to influence the information that providers uniformly provide to carriers prior to entering a carrier's network. Provider classifications in the regulations should also be consistent with those set forth in the Uniform Credentialing Form's licensure categories.

We look forward to discussing these and other ideas concerning the draft proposed regulations. Please do not hesitate to reach out should you have any questions on our comments.

Sincerely,



Deborah R. Rivkin

SAMPLING OF NEW ADMINISTRATIVE REQUIREMENTS

PROVIDER OUTREACH PROVISIONS

Monthly

- Regulation .03A(3) requires carriers to "ensure" that network providers are providing physical access, reasonable accommodations, and accessible equipment for disabilities on a monthly basis (section .03B requires us to monitor compliance with the Chapter monthly).

Quarterly

- The wait time regulations in Regulation .06A(5) require CareFirst to obtain 1000 responses (100 responses in each of ten provider categories) from providers concerning wait times. Depending on provider response rate, this would require well over ten thousand phone calls quarterly. Each provider would concurrently have to field these phone calls for all carriers subject these regulations, requiring a high volume of provider resources as well.

Annually

- To comply with Regulation .03A(6), carriers would need to survey specified providers to determine Board certifications (some of the certifications referenced are not included in the MIA's uniform credentialing form).
- To comply with Regulation .04C(5)(b), carriers would need to survey hospitals on provider panels annually to determine:

  (i) The percentage of on-call physicians practicing in the hospital who are participating providers;

  (ii) The percentage of hospital-based physicians practicing in the hospital who are participating providers;

  (iii) The percentage of anesthesiologists practicing in the hospital who are participating providers;

  (iv) The percentage of radiologists practicing in the hospital who are participating providers; and

  (v) A report of whether any non-physician providers, including laboratories or radiology facilities, within the hospital that routinely provide services to patients are not participating providers.
- Regulation .05A(1)(d)(iii) requires carriers to specify the percentage of facilities that provide alcohol treatment only, drug abuse only, or both. This would require facility surveys, as this information cannot be ascertained through provider licensing information. Licensure does not indicate whether services are rendered in a particular facility or practice.

MEMBER OUTREACH PROVISIONS

Quarterly

- Regulation .03B(2) requires carriers to monitor out of network costs to members and report this to the MIA on a quarterly basis. This would require a quarterly survey of all members, as carriers do not have access to members costs beyond what is provided for in our contracts.
- The wait time regulations in Regulation .06A(5) require CareFirst to obtain 1000 responses (100 responses in each of ten provider categories) from members concerning wait times. Depending on member response rate, this would require well over ten thousand phone calls quarterly.

Title 31 MARYLAND INSURANCE ADMINISTRATION

Subtitle 10 HEALTH INSURANCE — GENERAL

Chapter 44 Network Adequacy

Authority: Insurance Article, §§2-109(a)(1) and 15-112(a)—(d), Annotated Code of Maryland

.02 Definitions.

A. (text unchanged)

B. Terms Defined.

(1) (text unchanged)

(2) "Ambulatory infusion therapy center" means any location authorized to administer chemotherapy or infusion services on an outpatient basis.

[(2)**]** *(3)* – **[**(4)**]** *(5)* (text unchanged)

(6) "Drug and alcohol treatment program" means any organization or individual certified by the Maryland Department of Health in accordance with Title 10, Subtitle 47 of COMAR.

[(5)**]** *(7)* "Enrollee" means a person entitled to health care benefits from a carrier *under a policy or contract subject to Maryland law*.

[(6)**]** *(8)* "Essential community provider" means a provider that serves predominantly low-income or medically underserved individuals. "Essential community provider" includes:

(a) (text unchanged)

(b) Outpatient **[**behavioral**]** *mental* health and community based substance use disorder programs;**[**and**]**

(c) Any entity listed in 45 CFR §156.235(c)*; and* **[**.**]**

(d) School-based health centers.

[(7)**]** *(9)* – **[**(12)**]** *(14)* (text unchanged)

(15) "Hospital-based physician" has the meaning stated in Insurance Article, §14-201, Annotated Code of Maryland.

[(13)**]** *(16)* – **[**(14)**]** *(17) (text unchanged)*

[(15)**]** *(18)* "Network adequacy waiver **[**request**]**" means **[**a written request from a carrier to the Commissioner wherein the carrier seeks**]** the Commissioner's **[**approval to be relieved**]** *decision to relieve a carrier* of *the obligation to comply with* certain network adequacy standards in this chapter for 1 year.

(19) "On-call physician" has the meaning stated in Insurance Article, §14-201, Annotated Code of Maryland.

[(16)**]** *(20)* – **[**(21**]** *(25)* (text unchanged)

(26) "School-based health center" means a community health resource described in Health-General Article, § 19-2101, Annotated Code of Maryland that is located within an elementary, middle, or high school and approved by the Maryland State Department of Education.

[(22)**]** *(27)* – **[**(23)**]** *(28)* (text unchanged)

[(24)**]** *(29)* "Telehealth" **[**means:

(a) As it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a provider to deliver a health care service within the scope of practice of the provider at a location other than the location of the patient.

(b) "Telehealth" does not include:

(i) An audio-only telephone conversation between a provider and a patient;

(ii) An electronic mail message between a provider and a patient; or

(iii) A facsimile transmission between a provider and a patient.**]** *has the meaning stated in Insurance Article §15-139, Annotated Code of Maryland*.,

[(25)**]** *(30)* – [(26)**]** *(31)* (text unchanged)

[(27)**]** *(32)* "Waiting time" means the time from the initial request for health care services by an enrollee or by the enrollee's treating provider to the earliest date offered for the appointment for services *with a provider possessing the appropriate skill and expertise to treat the condition*.

.03 Network Adequacy Standards.

A. Sufficiency Standards.

(1) A carrier shall develop and maintain a complete network of adult and pediatric primary care, mental and behavioral health, substance use disorder, specialty care, ancillary service, vision, pharmacy, home health, and any other providers adequate to deliver the full scope of covered benefits.

(2) A carrier shall clearly define and specify referral requirements to specialty and other providers.

(3) A carrier shall ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities.

(4) A carrier's written policies and procedures to monitor availability of services shall include how the carrier will monitor the availability of services for:

(a) Continuity of care;

Commented [GC1]: We recommend revising to state "a provider possessing a license or certification to treat the condition". "Appropriate skill and expertise" is subjective—we credential providers to practice within the scope of their license/certification.

Commented [GC2]: We recommend striking "complete"—"complete network" is not defined. "Network" is a defined term in the regs (see current .02B(14)) and the statement "adequate to deliver the full scope of covered benefits" describes the requirements for the network.

Commented [GC3]: We recommend striking A(2) as redundant. These procedures are already on file with the Commissioner and made available to members as required by Maryland law.

(g) Copy of procedures filed with Commissioner. --
(1) Each carrier shall file with the Commissioner a copy of each of the procedures required under this section, including:
(i) steps the carrier requires of a member to request a referral;
(ii) the carrier's timeline for decisions; and
(iii) the carrier's grievance procedures for denials.
(2) Each carrier shall make a copy of each of the procedures filed under paragraph (1) of this subsection available to its members:
(i) in the carrier's online network directory required under § 15-112(n)(1) of this title; and
(ii) on request.

Md. INSURANCE Code Ann. § 15-830

Commented [CG4]: We recommend that this provision be revised to require carriers to take reasonable steps to ensure physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities. It is impossible for a carrier to literally "ensure" that each of the thousands of providers in our network are delivering the access and accommodations they attest to have in place during credentialing.

(b) Individuals with physical or mental disabilities, including physical access issues; and
(c) Individuals with limited English proficiency, including diverse cultural and ethnic backgrounds.
(5) A carrier shall ensure services are delivered in a culturally competent manner to all enrollees, including enrollees:
(a) With limited English proficiency;
(b) With diverse cultural and ethnic backgrounds; and
(c) Of all genders, sexual orientations, and gender identities.
(6) A carrier shall include in its annual plan under Regulation .04 of this chapter, by zip code, the number of providers by Board specialty, including but not limited to:
(a) The American Board of Medical Specialties;
(b) The American Board of Pharmacy Specialties;
(c) The American Board of Physical Therapy Specialties;
(d) The American Board of Professional Psychology;
(e) The Accreditation Board for Specialty Nursing Certification; and
(f) The American Academy of Nurse Practitioners Certification Board.
B. Monitoring Sufficiency Standards.
(1) A carrier shall monitor its provider network for compliance with this chapter on at least a monthly basis; and
(2) A carrier shall monitor out of network costs to members when network providers are not available and report this information on a form provided by the Administration on a quarterly basis.

[.03] .*04* Filing of Access Plan.

A. Using the instructions on the Maryland Insurance Administration's website *for submission method and* to determine rural, suburban, and urban zip code areas, each carrier subject to this chapter shall file an annual access plan with the Commissioner **[**through the System for Electronic Rate and Form Filing (SERFF)**]** on or before July 1 of each year for each provider panel used by the carrier, with the first access plan filing due on or before July 1, 2018.

B. (text unchanged)

C. Each annual access plan filed with the Commissioner shall include *the following information in the standardized format described on the Maryland Insurance Administration's website*:

(1) An executive summary in the form set forth in Regulation **[**.09**]** *.10* of this chapter;

(2) (text unchanged)

(3) The description required by Insurance Article, §15-112(c)(4)(iv) shall include:

(a) The number of primary care physicians, including pediatricians, family practitioners, and internists, who report to the carrier that they use any of the following languages in their practices:

(i) American Sign Language;
(ii) Spanish;
(iii) Korean;
(iv) Chinese (Mandarin or Cantonese);
(v) Tagalog; or
(vi) French;

(b) A description of outreach efforts to recruit and retain providers from diverse cultural or ethnic backgrounds;

(c) A copy of the most recent enrollees' language needs assessment made by or on behalf of the carrier, if one was made;

(d) A copy of the most recent demographic profile of the enrollee population made by or on behalf of the carrier, if one was made;

(e) A copy of any analysis or assessment made of provider network requirements based on an assessment of language needs or demographic profile of the enrollee population;

(f) A copy of any provider manual provisions that describe requirements for access to individuals with physical or mental disabilities; and

(g) Copies of policies and procedures documents designed to ensure that the provider network is sufficient to address the needs of both adult and child enrollees, including adults and children with:

(i) Limited English proficiency or illiteracy;
(ii) Diverse cultural or ethnic backgrounds;
(iii) Physical or mental disabilities; and
(iv) Serious, chronic, or complex health conditions.

[(3)**]** *(4)* Documentation justifying to the Commissioner how the access plan meets each network sufficiency standard set forth in Regulations **[**.04**]** *(.05)* — **[**.06**]** *(.07)* of this chapter; **[**and**]**

(5) A description of the network access to hospital-based providers, which shall include:

(a) A list of all the hospitals included on the provider panel; and

(b) For each hospital included on the provider panel:

(i) The percentage of on-call physicians practicing in the hospital who are participating providers;
(ii) The percentage of hospital-based physicians practicing in the hospital who are participating providers;
(iii) The percentage of anesthesiologists practicing in the hospital who are participating providers;
(iv) The percentage of radiologists practicing in the hospital who are participating providers; and

Commented [CG5]: We recommend that this provision be revised to require carriers to take reasonable steps to ensure services are delivered in a culturally competent manner to all enrollees. It is impossible for a carrier to literally "ensure" that each provider delivers care in a culturally competent manner.

Commented [GC6]: We recommend conforming this language to provider Board specialty categories in the Uniform Credentialing Form. Also, we are curious about the policy purpose of collecting this information, since certification is not required to be credentialed, nor is it required for network adequacy.

Commented [CG7]: We recommend striking "on at least a monthly basis". *As an alternative to monthly audits, which are extremely time consuming and costly, carriers could submit policies and procedures to MIA as part of the access plan that outlines how we are monitoring network adequacy compliance on an ongoing basis, as required by the statute.*

Commented [GC8]: We recommend amending this provision. (1) Cost to members accessing services out of network is not an indicator of network adequacy. Cost alone does not address the frequency with which our members obtain services out of network. (2) We have no ability to determine what a provider is charging a member outside of the out of network cost-share amount in our contract. (3) We do not know if a member has gone out of network by choice, or because they could not find someone in network.
As an alternative to this language, carriers could provide data around which provider types are accessed out of network most frequently in each geographic area served by the network.

(v) A report of whether any non-physician providers, including laboratories or radiology facilities, within the hospital that routinely provide services to patients are not participating providers; and

[(4)**]** *(6)* (text unchanged)

[.04] .*05* Travel Distance Standards.

A. Sufficiency Standards.

(1) Standard and Methodology

[(1)**]** *(a)* Except as stated in §B of this regulation, each provider panel of a carrier shall have within the geographic area served by the carrier's network or networks, sufficient primary care physicians, specialty providers, **[**behavioral**]** *mental* health and substance use disorder providers, hospitals, and health care facilities to meet the maximum travel distance standards listed in the chart in §A(5) of this regulation for each type of geographic area.

(b) The distances listed in §A(5) of this regulation shall be:

(i) **[**measured**]** *Measured* from the *practicing location of the provider or facility to the* enrollee's place of residence**[**.**]***; and*

(ii) Calculated based on road travel distance.

(c) Except for those provider types excluded under §A(3) of this regulation, for each provider type and facility type included on the carrier's provider panel, the carrier shall:

(i) Map the practicing locations of every network provider within the geographic area served by the carrier's network or networks;

(ii) Identify any geographic areas within each Maryland zip code that fall outside of the applicable distance standard based on road travel distance from the provider location;

(iii) For each zip code identify the total number of enrollees residing in the zip code and the number of enrollees residing within an area where the applicable distance standard is not met;

(iv) For each zip code calculate the percentage of enrollees residing within an area where the applicable distance standard is met;

(v) For each of the urban, rural, and suburban areas identify the total number of enrollees residing in the geographic area;

(vi) For each of the urban, rural, and suburban areas identify the total number of enrollees residing within an area where the applicable distance standard is not met; and

(vii) For each of the urban, rural, and suburban areas identify the percentage of enrollees residing within an area where the applicable distance standard is met.

(d) A carrier shall submit, as part of its documentation justifying to the Commissioner how the access plan meets the network sufficiency standards in this regulation:

(i) Geo-access maps for each provider type and facility type except for those excluded under §A(3) of this regulation showing the practicing locations of network providers and identifying any geographic areas within each zip code where the applicable distance standard is not met;

(ii) For zip codes where a significant portion of the population does not own a personal automobile, a description of any analysis or assessment of how public transportation is taken into account when considering enrollees' access to care under the travel distance standards; and

(iii) For any facility types listed in §A(5) of this regulation the provider services for substance use disorders, the percentage of facilities on the carrier's provider panel that provide services for alcohol treatment only, drug abuse treatment only, and alcohol and drug abuse treatment.

(e) A carrier shall report each number and percentage described in §A(1)(c)(iii)-(viii) of this regulation as part of the annual access plan filing.

(2) – (3) (text unchanged)

(4) All other providers and facility types *included on the carrier's provider panel but* not listed in the chart in §A(5) of this regulation*, including physical therapists, nutritionists, and dietitians,* shall individually be required to meet maximum distances standards of 15 miles for Urban Areas, 40 miles for Suburban Areas, and 90 miles for Rural Areas.

(5) Chart of Travel Distance Standards.

	Urban Area Maximum Distance (miles)	Suburban Area Maximum Distance (miles)	Rural Area Maximum Distance (miles)
Provider Type:			
Allergy and Immunology	15	30	75
Applied Behavioral Analyst	15	30	60

Commented [CG9]: We recommend exploring a more efficient way for hospitals to provide this data. Carriers do not have this level of hospital data and would need to request the information from participating hospitals. A carrier's ability to comply with this requirement would be dependent on hospitals providing timely and accurate information, which is outside of our control.

Commented [CG10]: We recommend a revision to the proposed regulation to make it clear that identifying the locations of members (in lieu of geographic areas within a zip code) is also permissible.

Commented [CG11]: Who is providing this information to carriers concerning the portion of a population that does not own a personal automobile? Will the MIA identify these areas or a source for this information so that it is uniform among carriers? Carriers do not collect information about automobile access.

Commented [GC12]: This information cannot be ascertained through facility provider licensing information. Facility Providers are licensed and credentialed under the category: "Alcohol and/or Drug and/or Mental Health Rehab Center." Licensure does not indicate which specific services are rendered in a particular facility or practice.

Commented [GC13]: (1) **We recommend conforming the provider types to the uniform credentialing form categories. (2) Because medical providers also provide behavioral healthcare services, we recommend that carriers be permitted to include such providers in both categories**. For example, many PCPs perform behavioral health services and prescribe medications for behavioral health conditions.

Cardiovascular Disease	10	20	60
Child Psychiatry	*10*	*25*	*60*
Chiropractic	15	30	75
Dermatology	10	30	60
Endocrinology	15	40	90
ENT/Otolaryngology	15	30	75
Gastroenterology	10	30	60
General Surgery	10	20	60
Geriatric Psychiatry	*10*	*25*	*60*
Gynecology, OB/GYN	5	10	30
Gynecology Only	15	30	75
Licensed Clinical Social Worker	10	25	60
Licensed Professional Counselor	*10*	*25*	*60*
Nephrology	15	25	75
Neurology	10	30	60
Oncology-Medical and Surgical	10	20	60
Oncology-Radiation/Radiation Oncology	15	40	90
Ophthalmology	10	20	60
Pediatrics-Routine/Primary Care	5	10	30
Physiatry, Rehabilitative Medicine	15	30	75
Physician Certified in Addiction Medicine	*10*	*25*	*60*
Plastic Surgery	15	40	90
Podiatry	10	30	60
Primary Care Physician *(non-pediatric)*	5	10	30
Psychiatry	10	25	60
Psychology	10	25	60
Pulmonology	10	30	60
Rheumatology	15	40	90
Urology	10	30	60
All Other licensed or certified providers under contract with a carrier not listed	15	40	90
Facility Type:			
Acute Inpatient Hospitals	10	30	60
Ambulatory Infusion Therapy Centers	*10*	*30*	*60*
Critical Care Services — Intensive Care Units	10	30	100

Diagnostic Radiology	10	30	60
Drug and Alcohol Treatment Program	*10*	*25*	*60*
Inpatient Psychiatric Facility	15	45	75
Outpatient Dialysis	10	30	50
[Outpatient Infusion/Chemotherapy	10	30	60**]**
Outpatient Mental Health Clinic	*15*	*30*	*60*
Outpatient Substance Use Disorder Facility	*15*	*30*	*60*
Pharmacy	5	10	30
Skilled Nursing Facilities	10	30	60
Substance Use Disorder Residential Treatment Facility	*10*	*25*	*60*
Surgical Services (Outpatient or Ambulatory Surgical Center)	10	30	60
[Other Behavioral Health/Substance Abuse Facilities	10	25	60**]**
All other licensed or certified facilities under contract with a carrier not listed	15	40	90

B. Group Model HMO Plans Sufficiency Standards.

Commented [CG14]: See comments to Section A above.

(1) Standard and Methodology

[(1)**]** *(a)* Each group model HMO's health benefit plan's provider panel shall have within the geographic area served by the group model HMO's network or networks, sufficient primary care physicians, specialty providers, **[**behavioral**]** *mental* health and substance use disorder providers, hospitals, and health care facilities to meet the maximum travel distance standards listed in the chart in §B(5) of this regulation for each type geographic area.

(b) The distances listed in §B(5) of this regulation shall be:

*(i)***[**measured**]** *Measured* from the *practicing location of the provider or facility to the* enrollee's place of residence or place of employment from which the enrollee gains eligibility for participation in the group model HMO's health benefit plan**[**.**]***; and*

(ii) Calculated based on road travel distance.

(c) Except for those provider types excluded §B(3) of this regulation, for each provider type and facility type included on the group model HMO's provider panel, the carrier shall:

(i) Map the practicing locations of every network provider within the geographic area served by the group model HMO's network or networks;

(ii) Identify any geographic areas within each Maryland zip code that fall outside of the applicable distance standard based on road travel distance from the provider locations;

(iii) For each zip code identify the total number of enrollees with a residence or place of employment in the zip code and the number of enrollees with a residence or a place of employment within an area where the applicable distance standard is not met;

(iv) For each zip code calculate the percentage of enrollees with a residence or place of employment within an area where the applicable distance standard is met;

(v) For each of the urban, rural, and suburban areas identify the total number of enrollees with a residence or place of employment in the geographic area;

(vi) For each of the urban, rural, and suburban areas identify the number of enrollees with a residence or place of employment within an area where the applicable distance standard is not met; and

(vii) For each of the urban, rural, and suburban areas identify the percentage of enrollees with a residence or place of employment within an area where the applicable distance standard is met.

(d) When calculating the number or percentage of enrollees with a place of employment within an area or zip code under §B(1)(c)(iii)-(viii) of this regulation, the carrier shall include only those enrollees who gain eligibility for participation in the group model HMO's health benefit plan from their place of employment.

(e) A carrier shall submit, as part of its documentation justifying to the Commissioner how the access plan meets the network sufficiency standards in this regulation:

(i) Geo-access maps for each provider type and facility type except for those excluded under §B(3) of this regulation showing the practicing locations of network providers and identifying any geographic areas within each zip code where the applicable distance standard is not met;

(ii) For zip codes where a significant portion of the population does not own a personal automobile, a description of any analysis or assessment of how public transportation is taken into account when considering enrollees' access to care under the travel distance standards; and

(iii) For any facility types listed in §B(5) of this regulation that provide services for substance use disorders, the percentage of facilities on the carrier's provider panel that provide services for alcohol treatment only, drug abuse treatment only, and alcohol and drug abuse treatment.

(f) A carrier shall report each number and percentage described in §B(1)(c)(iii)-(viii) of this regulation as part of the annual access plan filing.

(2) – (3) (text unchanged)

(4) All other provider and facility types *included on the carrier's provider panel, but* not listed in the chart at §B(5) of this regulation*, including physical therapists, nutritionists, and dietitians,* shall individually be required to meet maximum distances standards of 15 miles for Urban Areas, 40 miles for Suburban Areas, and 90 miles for Rural Areas.

(5) Chart of Travel Distance Standards.

	Urban Area Maximum Distance (miles)	Suburban Area Maximum Distance (miles)	Rural Area Maximum Distance (miles)
Provider Type:			
Allergy and Immunology	20	30	75
Applied Behavioral Analyst	15	20	60
Cardiovascular Disease	15	25	60
Child Psychiatry	*15*	*30*	*75*
Chiropractic	20	30	75
Dermatology	20	30	60
Endocrinology	20	40	90
ENT/Otolaryngology	20	30	75
Gastroenterology	20	30	60
General Surgery	20	30	60
Geriatric Psychiatry	*15*	*30*	*75*
Gynecology, OB/GYN	15	20	45
Gynecology Only	15	30	60
Licensed Clinical Social Worker	15	30	75
Licensed Professional Counselor	*15*	*30*	*75*
Nephrology	15	30	75
Neurology	15	30	60
Oncology-Medical, Surgical	15	30	60
Oncology-Radiation/Radiation Oncology	15	40	90
Ophthalmology	15	20	60
Pediatrics-Routine/Primary Care	15	20	45
Physiatry, Rehabilitative Medicine	15	30	75

Physician Certified in Addiction Medicine	*15*	*30*	*75*
Plastic Surgery	15	40	90
Podiatry	15	30	90
Primary Care Physician *(non-pediatric)*	15	20	45
Psychiatry	15	30	60
Psychology	15	30	60
Pulmonology	15	30	60
Rheumatology	15	40	90
Urology	15	30	60
All Other licensed or certified providers under contract with a carrier not listed	20	40	90
Facility Type:			
Acute Inpatient Hospitals	15	30	60
Ambulatory Infusion Therapy Center	*15*	*30*	*60*
Critical Care Services-Intensive Care Units	15	30	120
Diagnostic Radiology	15	30	60
Drug and Alcohol Treatment Program	*15*	*30*	*60*
Inpatient Psychiatric Facility	15	45	75
Outpatient Dialysis	15	30	60
[Outpatient Infusion/Chemotherapy	15	30	60**]**
Outpatient Mental Health Clinic	*15*	*30*	*60*
Outpatient Substance Use Disorder Facility	*15*	*30*	*60*
Pharmacy	5	10	30
Skilled Nursing Facilities	15	30	60
Substance Use Disorder Residential Treatment Facility	*15*	*30*	*60*
Surgical Services (Outpatient or Ambulatory Surgical Center)	10	30	60
[Other Behavioral Health/Substance Abuse Facilities	15	30	60**]**
All other licensed or certified facilities under contract with a carrier not listed	15	40	120

C. Essential Community Providers.

(1) Each provider panel of a carrier, that is not a group model HMO provider panel, shall include*:*

*(a)***[**at**]** *At* least 30 percent of the available essential community providers *providing medical services* in each of the urban, rural, and suburban areas**[.]***;*

(b) At least 30 percent of the available essential community providers providing mental health services in each of the urban, rural, and suburban areas; and

(c) At least 30 percent of the available essential community providers providing substance use disorder services in each of the urban, rural, and suburban areas.

(2) Methodology for calculating essential community provider inclusion standard.

Commented [CG15]: We recommend striking the amendments to this section. The federal ECP law applies the 30% in-network standard to *all* ECPs, not specific subsets of ECPs.

(a) Except as provided in §§C(2)(b) and (c) of this regulation, a carrier shall use the MHBE ECP Network Inclusion Calculation Methodology that is described in the Instructions on Meeting the Essential Community Provider Plan Certification Standard guidance provided by the Maryland Health Benefit Exchange, which is current as of the date three months prior to the due date of the annual access plan.

(b) The calculation described in §C(2)(a) of this regulation shall be performed separately for essential community providers providing medical services, mental health services, and substance use disorder services in each of the urban, rural, and suburban areas.

(c) If the Maryland Health Benefit Exchange changes the MHBE ECP Network Inclusion Calculation Methodology after the effective date of this regulation, a carrier may not use the revised methodology to calculate the essential community provider inclusion standard in §C(1) of this regulation unless the Commissioner has approved the revised methodology for this purpose.

[(2)**]** *(3)* – **[**(3)**]** *(4)* (text unchanged)

[.05] .*06* Appointment Waiting Time Standards.

A. Network capacity.

(1) Each carrier shall create and utilize written policies and procedures to monitor the availability of services.

(2) On a quarterly basis, each carrier shall make available to its members the median wait times to obtain the following appointments with a participating provider within the applicable maximum travel distance standards described in Regulation .05 of this chapter as measured from the date of the initial request to the date of the earliest available appointment:

(a) Urgent care for medical services;
(b) Inpatient urgent care for mental health services;
(c)Inpatient urgent care for substance use disorder services;
(d) Outpatient urgent care for mental health services;
(e)Outpatient urgent care for substance use disorder services;
(f) Routine primary care;
(g) Preventive care/well visits;
(h) Non-urgent specialty care;
(i) Non-urgent mental health care; and
(j) Non-urgent substance use disorder care.

(3) To monitor availability of providers, a carrier shall:

(a) Ensure the accuracy of its provider directory;
(b) Utilize a survey tool with members;
(c) Make direct contact with a random selection of provider offices qualified to provide the services for each of the appointment types listed in §A(2) of this regulation to ask for next available appointments; and
(d)Retain documentation of the efforts described in §A(3)(a) – (c) of this regulation.

(4) The survey tool described in §A(3)(b) of this regulation shall:

(a) Utilize a statistically valid method to ensure that survey respondents are selected in a random manner;
(b) Ask members to provide the time period from the date of the initial request for each appointment type listed in §A(2) of this regulation to the earliest date offered for an appointment with a participating provider possessing the appropriate skill and expertise to treat the condition; and
(c) Ensure a minimum sample size of responsive answers for each appointment type listed in §A(2) of this regulation that is equivalent to the lesser of:
(i) Ten percent of claims received by the carrier for that appointment type in the same quarter of the preceding calendar year; or
(ii) One hundred answers.

(5) The minimum sample size for the random selection of provider offices described in §A(3)(c) of this regulation shall be equivalent to the lesser of:

(a) Ten percent of the participating providers qualified to provide the services for each of the appointment types listed in §A(2) of this regulation; or
(b) One hundred provider offices.

(6) The median wait times described in §A(2) of this regulation shall be calculated by:

(a) Determining the median wait time based on the results of the member surveys described in §A(3)(b) of this regulation and multiplying that number by 0.25;
(b) Determining the median wait time based on the direct contacts with provider offices described in §A(3)(c) of this regulation and multiplying that number by 0.75; and
(c) Adding the results in §A(6)(a) and §A(6)(b) of this regulation.

[A.**]** *B.* Sufficiency Standards.

(1) On a quarterly basis, a carrier shall determine whether the provider panel meets the waiting time standards listed in §E of this regulation based on the member surveys and the direct contacts with provider offices described in §A(3)(b)-(c) of this regulation.

[(1)**]** *(2)* Subject to the exceptions in **[**§B**]** *§§C and D* of this regulation, **[**each carrier's provider panel shall meet the waiting time standards listed in §C of this regulation for at least 95 percent of the enrollees covered under health benefit plans

Commented [CG16]: This regulation imposes significant new quarterly auditing requirements in an effort to calculate median provider wait times. **CareFirst is exploring alternative metrics for wait times that would be more accurate and less burdensome on carriers and providers than this proposal (some discussed below). Among other concepts, we recommend consideration of awarding percentage credits to carrier wait time calculations based upon a carrier's implementation of innovative programs to aid members in obtaining timely appointments with qualified providers.**

Commented [CG17]: **We recommend that this provision be revised to require carriers to have procedures in place to maintain an accurate provider directory.** The accuracy of our provider directories depends on receiving timely and accurate information from providers. We can make every effort to obtain information from providers to ensure an accurate provider directory, but ultimately the accuracy depends on provider cooperation.

Commented [CG18]: We have concerns about a member's ability to recollect data about their first offered appointment, and to recollect whether telehealth was available as a viable alternative. [Note that under this proposal, carriers can count telehealth towards wait times if appropriate, available, and accessible].

Commented [CG19]: **CareFirst recommends that the MIA explore the following policy concepts for provider outreach concerning wait times: (1) whether one provider survey outsourced by the MIA for all carriers at a specified frequency would be more effective than a quarterly, carrier initiated survey. This would ensure consistency and limit the burden on providers of responding to multiple carrier calls per quarter; or (2) Requiring providers to list approximate wait times for an appointment either on their website and/or on their phone line. Only providers can speak to their true average scheduling availability—surveys are far less reliable, and variable based upon a variety of factors outside the scope of the questions (cancellations, new providers joining a practice, etc.).** These concepts may require authorizing legislation but would make results more accurate and meaningful in evaluating carrier compliance.

that use that provider panel**]** *if a carrier's provider panel fails to meet the waiting time standards listed in §E of this regulation for at least 90% of appointments in each category, the carrier shall notify the Administration within 10 business days identifying the deficiency in the provider network and the efforts that have been taken or will be taken to correct the deficiency*.

[(2)**]** *(3)* When **[**it**]** *a telehealth appointment* is clinically appropriate, *available, and accessible to* **[**and**]** an enrollee **[**elects to utilize a telehealth appointment**]**, a carrier may consider **[**that utilization**]** *the offer of that appointment* as a part of its meeting the standards listed in **[**§C**]** *§E* of this regulation.

[B.**]** *C.* Preventive care services and periodic follow-up care, including but not limited to, standing referrals to specialty providers for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or **[**behavioral**]** *mental* health or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating provider acting within the scope of the provider's license, certification, or other authorization.

D. A visit scheduled in advance in accordance with §C of this regulation may be disregarded when determining compliance with the waiting time standards listed in §E of this regulation.

[C.**]** *E.* Chart of Waiting Time Standards.

Waiting Time Standards	
Urgent care *for medical services* **[** (including] medical, behavioral health, and substance use disorder services)**]**	72 hours
Inpatient urgent care for mental health services	*72 hours*
Inpatient urgent care for substance use disorder services	*72 hours*
Outpatient urgent care for mental health services	*72 hours*
Outpatient urgent care for substance use disorder services	*72 hours*
Routine primary care	15 calendar days
Preventive **[**visit**]** *care*/well visit	30 calendar days
Non-urgent specialty care	30 calendar days
Non-urgent mental health care	*10 calendar days*
Non-urgent **[**behavioral health/**]**substance use disorder **[**services**]** *care*	10 calendar days

F. On a quarterly basis, each carrier shall forward to the Administration a list of complaints it receives relating to the unavailability of a provider.

[.06] *.07* Provider-to-Enrollee Ratio Standards.

A. (text unchanged)

Commented [CG20]: **CareFirst recommends reevaluating the appropriate reporting mechanism for wait time deficiency after it finalizes the appropriate wait time metric.**

Commented [GC21]: CareFirst agrees that telehealth services that are clinically appropriate, available, and accessible to an enrollee should be included in wait time calculations; however, measuring the subjective accessibility of telehealth to members is not possible. **To account for the availability of telehealth to members, CareFirst recommends that the MIA explore the concept of awarding a percentage credit to a carrier's wait time calculation based upon a carrier meeting specified thresholds for telehealth availability (see the CMS rules for Part D/MA).**

Commented [CG23]: **CareFirst recommends that routine, preventative, and nonurgent wait times should be evaluated against industry standards.** CareFirst is currently studying this.

Commented [GC22]: **Because medical providers also provide behavioral healthcare and SUD services, we recommend that carriers be permitted to include such providers in both categories.**

B. The provider-to-enrollee ratios shall be equivalent to at least 1 full-time physician, or as appropriate, another full-time provider for:

(1) – (3) (text unchanged)

(4) 2,000 enrollees for **[**behavioral**]** *mental* health care or services; and

(5) (text unchanged)

C. The ratios described in §B of this regulation shall be calculated based on:

(1) The number of enrollees covered under all health benefit plans issues by the carrier in Maryland that use that provider panel; and

(2) The number of providers in that provider panel with practicing locations:

(a) In Maryland; or

(b) Within the applicable maximum travel distance standard specified in Regulation .04 of this chapter outside the geographic boundaries of Maryland.

[.07] .*08 Network Adequacy* Waiver [Request] Standards.

A. **[**A carrier may apply for a network adequacy waiver, for up to 1 year, of a network adequacy requirement listed in this chapter.**]** *If a carrier's provider panel fails to meet one or more of the standards specified in Regulations .05-.07 of this chapter, the carrier shall provide the following information to the Commissioner as part of the annual access plan:*

(1) A description of any network adequacy waiver previously granted by the Commissioner;

(2) An explanation of how many providers in each specialty or health care facility type that the carrier reasonably estimates it would need to contract with to satisfy each unmet standard;

(3) A description of the methodology used to calculate the estimated number of providers in §A(2);

(4) A list of physicians, other providers, or health care facilities related to each unmet standard and within the relevant service area that the carrier attempted to contract with, identified by name and specialty, if any, or health care facility type;

(5) A description of how and when the carrier last contacted the physicians, other providers, or health care facilities;

(6) A description of any reason each physician, other provider, or health care facility gave for refusing to contract with the carrier;

(7) Identification of all incentives the carrier offers to providers to join the network;

(8) If applicable, a statement that there are no physicians, other providers, or health care facilities available within the relevant service area for a covered service or services for which the carrier failed to meet a standard;

(9) A detailed description of other efforts and initiatives undertaken by the carrier in the past year to enhance its network and address the deficiencies that contributed to each unmet standard;

(10) A description of steps the carrier will take to attempt to improve its network to avoid a future failure to meet a standard; and

(11) An attestation to the accuracy of the information provided in relation to each unmet standard.

B. The Commissioner may find good cause to grant **[**the**]** *a* network adequacy waiver **[**request**]** *of one or more of the standards specified in Regulations .05-.07 of this chapter,* if *the information provided by* the carrier *under §A of this regulation* demonstrates that the physicians, other providers, or health care facilities necessary for an adequate network:

(1) – (4) (text unchanged)

C. **[**A carrier seeking a network adequacy waiver shall submit a written request to the Commissioner that includes the following information:

(1) A description of any waiver previously granted by the Commissioner;

(2) A list of physicians, other providers, or health care facilities within the relevant service area that the carrier attempted to contract with, identified by name and specialty, if any, or health care facility type;

(3) A description of how and when the carrier last contacted the physicians, other providers, or health care facilities;

(4) A description of any reason each physician, other provider, or health care facility gave for refusing to contract with the carrier;

(5) Steps the carrier will take to attempt to improve its network to avoid future network adequacy waiver requests;

(6) If applicable, a statement that there are no physicians, other providers, or health care facilities available within the relevant service area for a covered service or services for which the carrier requests the waiver; and

(7) An attestation to the accuracy of the information contained in the network adequacy waiver request.**]** *The Commissioner shall post a list of all network adequacy waivers that are granted for each annual access plan on the Maryland Insurance Administration's website.*

[.08] .*09* Confidential Information in Access Plans.

A. Subject to §15-802 of the Insurance Article, Annotated Code of Maryland, the following information that is included in a carrier's access plan shall be considered confidential by the Commissioner:

(1) **[**Methodology**]** *Proprietary methodology* used to annually assess the carrier's performance in meeting the standards established under this chapter;

(2) **[**Methodology**]** *Proprietary methodology* used to annually measure timely access to health care services; and

(3) (text unchanged)

B. A carrier submitting an access plan or **[**a**]** *supplemental information required for the* network adequacy waiver **[**request**]** *standards* may submit a written request to the Commissioner that specific information included in the plan **[**or request**]** not be disclosed under the Public Information Act and shall:

Commented [CG24]: Carriers do not have a baseline source of truth for the number of licensed, practicing providers in Maryland. Therefore**, we cannot reasonably estimate how many providers it would take to meet wait time standards. We continue to support legislation requiring state licensing boards to collect and report the number of licensed practicing providers in each category in the state, which will provide a source of truth concerning the depth of the provider work force in Maryland.**

Commented [CG25]: See previous comment.

Commented [CG26]: We recommend deleting "detailed"— other provisions in this section do not use this adjective.

Commented [CG27]: We recommend changing to "*The Commissioner shall post a list of all carriers that are granted network adequacy waivers on the Maryland Insurance Administration's website.*"

(1) – (2) (text unchanged)

C. – D. (text unchanged)

[.09] .*10* Network Adequacy Access Plan Executive Summary Form.

A. For each provider panel used by a carrier for a health benefit plan, the carrier shall provide the *following* network sufficiency results for the health benefit plan service area **[**as follows**]** *in the standardized format described on the Maryland Insurance Administration's website*:

(1) Travel Distance Standards.

(a) For each provider type *and facility type* listed in Regulation **[**.04**]** *.05*, list the percentage of enrollees for which the carrier met the travel distance standards, in the following format:

	Urban Area	Suburban Area	Rural Area
Primary Care Provider			
Specialty Provider			

(b) All provider and facility types described in §§ A(4) and B(4) of Regulation .05 of this chapter and included on the carrier's provider panel shall be listed individually in the chart described in §A(1)(a) of this regulation with the corresponding data for that specific type of provider or facility.

[(b)**]** *(c)* – **[**(c)**]** *(d)* (text unchanged)

[(d)] *(e)* List the total number of essential community providers in the carrier's network *in each of the urban, rural, and suburban areas providing:*

(i) Medical services;

(ii) Mental health services; and

(iii) Substance use disorder services.

[(e)**]** *(f)* List the total percentage of essential community providers available in the health benefit plan's service area that are participating providers *for each of the nine categories described in §A(1)(e) of this regulation*.

(g) List the total number and percentage of local health departments in the carrier's network providing:

(i) Medical services;

(ii) Mental health services; and

(iii) Substance use disorder services.

(2) Appointment Waiting Time Standards.

(a) For each appointment type listed in Regulation **[**.05**]** *.06*, list the **[**percentage of enrollees for which the carrier met the appointment wait time standards**]** *calculated median wait time to obtain an appointment with a participating provider within the applicable maximum travel distance standards described in Regulation .05 of this chapter*, in the following format:

Appointment Waiting Time Standard Results
Urgent care *for medical services* **[** — within 72 hours**]**
Inpatient urgent care for mental health services
Inpatient urgent care for substance use disorder services
Outpatient urgent care for mental health services
Outpatient urgent care for substance use disorder services
Routine primary care **[**— within 15 calendar days**]**
[Preventative Visit**]** *Preventive care*/Well Visit**[** — within 30 calendar days**]**
Non-urgent specialty care **[**— within 30 calendar days**]**

Commented [GC28]: Can there be a mechanism in place for the MIA to propose any changes in the website form to carriers with the opportunity to comment?

Commented [CG29]: See comments on ECP regulation above.

Commented [CG30]: Carriers may not have this level of data (we are looking into this for local health departments). The Uniform Credentialing Application generally concerns services permitted under the scope of a facility provider's license-not services offered and available under a facility's business model. The presence of a license for certain services does not necessarily indicate the availability of those services to members.

[Non-urgent ancillary services — within 30 calendar days**]**
Non-urgent **[**behavioral**]** *mental* health**[**/substance use disorder services — within 10 calendar days**]** *care*
Non-urgent substance use disorder care

(b) List the total **[**percentage**]** *number* of telehealth appointments counted as part of the appointment waiting time standard results *for each type of visit*.

(c) List the percentage of appointments counted as part of the appointment waiting time standard results for each type of visit that were telehealth appointments.

(3) Provider-to-Enrollee Ratio Standards.

(a) (text unchanged)

(b) For all other carriers, **[**list whether the percentage of provider-to-enrollee ratios meet the**]** *summarize the network performance for each* provider-to-enrollee ratio **[**standards**]** *standard* listed in Regulation **[**.06**]** *.07* of this chapter *by listing the calculated number of providers in the provider panel, rounded to the nearest whole number,* for each of the following categories *of enrollees*:

(i) – (iii) (text unchanged)

(iv) 2,000 enrollees for **[**behavioral**]** *mental* health care or service; and

(v) (text unchanged)

B. (text unchanged)

Commented [CG31]: See comments above. We are unclear how to measure subjective enrollee *access* to telehealth.