



August 9, 2022

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

Re: Proposed Draft Chapter 44 Network Adequacy Regulations

Dear Commissioner Birrane:

On behalf of the Legal Action Center and the 14 undersigned organizations and individuals, thank you for the opportunity to submit comments on the revised proposed draft Network Adequacy regulations. 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 and mental health conditions, 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 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 and, with the increased use of telehealth, protections that allow consumers, in consultation with their providers, to choose the mode of service delivery that meets their health needs.

We appreciate the Maryland Insurance Administration's (MIA) on-going work to gather relevant data to better track whether carrier networks include the full range of providers of mental health (MH) and substance use disorders (SUD) and to examine carrier practices that address the inclusion of practitioners that meet the health needs of all Marylanders across racial, ethnic, gender, sexual orientation, gender identity and disability identities. Maryland's unrelenting overdose epidemic, which disproportionately affects Black Marylanders, and overwhelming need for mental health treatment to address the impact and disruption of COVID, particularly devastating for Black and Indigenous communities, calls for heightened oversight and improvement of carrier networks.

The highlights to our comments include:

- We support the MIA's Access Plan standards that would gather essential information on out-of-network (OON) utilization under the No Surprises Act and Ins. Art. § 15-830, most common OON utilization by provider type, single case agreements (with requested modifications), telehealth utilization (with requested modifications), and complaint data related to network provider access. **This critical data should be made available to the Maryland General Assembly in aggregate data reports and through briefings to**

inform policy development and ensure transparency for the public as well as employers who seek accessible MH and SUD benefits for their workforce.

- We support the MIA’s Access Plan standards that would gather essential information on out-of-network (OON) utilization under the No Surprises Act and Ins. Art. § 15-830, most common OON utilization by provider type, single case agreements (with requested modifications), telehealth utilization (with requested modifications), and complaint data related to network provider access. **This critical data should be made available to the Maryland General Assembly in aggregate data reports and through briefings to inform policy development and ensure transparency for the public as well as employers who seek accessible MH and SUD benefits for their workforce.**
- We appreciate the retention of standards from the previous draft rule which would increase the granularity of data regarding MH and SUD provider/facility types and appointment types that carriers must report to the MIA and the public. **We also support several newly proposed standards that will identify the availability of adolescent MH and SUD services. We, however, oppose proposed revisions to the Executive Summary that would remove identification of the appointment wait time values and the percentage of satisfaction for each appointment type.**
- **We agree that telehealth services should be counted for satisfaction of appointment wait time and travel distance metrics, as they have for the past 5 years for appointment wait time, but we oppose the proposed telehealth standard that would remove enrollee election as a criterion for meeting such metrics.** Widespread recognition that the patient’s needs and preferences must be at the center of all telehealth utilization decisions requires a direct accounting of enrollee election to assess network adequacy. The 2022 Network Adequacy reports reveal that two carriers calculate the current telehealth standard for satisfaction of the appointment wait time metric, which requires the telehealth visit to be clinically appropriate and elected by the member. **There is no reason that all carriers cannot collect and report information on both consumer election and claims data coded for telehealth utilization to support the use of telehealth for appointment wait time and the travel distance metric.**
- We appreciate the proposed requirement that carriers submit data to demonstrate “clinical appropriateness, availability and accessibility,” to claim the proposed telehealth credit, **but we oppose the use of a “telehealth credit” to meet adequacy requirements until sufficient data are gathered to support a telehealth credit request.** Carriers have had the opportunity to claim a “credit” for telehealth services for 5 years, but few have done so until the pandemic, and others still have not presented data to support a telehealth count for appointment wait time. (See Attachment A – 2022 Network Adequacy Executive Summary). **For purposes of enforcement, we also oppose the use of an artificial advantage to permit carriers to avoid penalties for maintaining inadequate networks. Additionally, the relationship between the use of a telehealth credit and the mandatory reporting of waiver standards in annual access plans is unclear.** To the extent the use of a credit allows carriers to avoid waiver reporting under Sec. 09, the MIA and policymakers will lose access to valuable information about the source of network deficiencies and carrier efforts to contract with providers of MH and SUD services and, as a result, the ability to identify strategies to improve network coverage.

- **Regardless of the process for counting telehealth utilization, carriers must be required to inform enrollees of their right to in-person services.** The Preserve Telehealth Act of 2021 (SB 3) bars carriers from denying coverage for an in-person MH or SUD service solely because it may be covered through a telehealth benefit. Ins. Art. § 15-139(c)(1)(iii). Notification is the only way to enforce this right. It is particularly critical for enrollees seeking MH and SUD services because such services are deemed to be more amenable to virtual care delivery, and carriers have developed and implemented telehealth-only MH and SUD platforms that unacceptably steer consumers to telehealth services.

Below is specific and additional detail related to these highlights.

I. Network Adequacy Standards and Monitoring Sufficiency Standards – Sec. 31.10.44.03

The proposed rule clearly identifies the carrier’s obligation to maintain adequate networks, implement policies to address network deficiencies, identify referral policies and take steps to ensure that its provider network delivers culturally competent care for all enrollees based on a wide range of protected classifications and identities. We specifically support the proposed revision that would require carriers to address access to services that are delivered in a culturally competent manner based on enrollees’ race (in addition to other designated identities). We urge the MIA to expand the provision to include several standards that would improve monitoring.

A. Number of Providers In-Network

We support the MIA’s proposal to use the uniform credentialing form, described in Ins. Art. § 15-112.1, as the basis for reporting the number of providers by zip code in a carrier’s network. We are concerned, however, that the uniform credentialing form does not capture facilities, which, in the context of MH and SUD services, deliver a substantial amount of care. The absence of that data could undercount the carrier’s network of MH and SUD care. We recognize that Sec. .03(A)(8)(b) would allow for the identification of additional participating providers based on other documentation, **but we urge the MIA to require the reporting of facility-based services, using, at a minimum, the list of facilities in Sec. 05.**

In addition, the proposed draft would not require carriers to report data on the “number of providers” in its access plans, leaving that requirement to the MIA’s discretion. *See* Sec. .04(D). **This is essential information, and we urge the MIA to require inclusion of this information in the carrier’s annual access plan.**

B. Monitoring Sufficiency Standards

The proposed rule would require carriers to conduct internal audits of their networks for compliance at least quarterly but does not include a reporting requirement that would confirm completion of each such audit. (We recognize that Sec. .06(B)(2) would require carriers to report wait time data on a semi-annual basis.) **We urge the MIA to require carriers to submit an affirmation by an official with authority to represent the carrier that attests to the completion of the required internal audits.**

The proposed rule has also added a requirement that carriers must continuously verify and update their network directory but does not include any reporting requirement that would demonstrate or confirm that a review and update has been conducted. One of the most informative markers of active participation in a carrier’s network is the provider’s billing pattern; networks that contain providers who have not billed for services in 6 or 12 months may include inactive providers that misrepresent the breadth of the network. **We urge the MIA to require carriers to demonstrate that they are verifying and updating their networks by reporting on the number of providers who have not billed in 6 and 12 months at each quarterly audit.** Such reporting has the value of tracking active providers without disincentivizing inactive providers from future patient care and billing.

To ensure transparent access to a carrier’s overall service delivery landscape, provider directories should note the service delivery options available for each provider – and particularly each MH and SUD provider listed – identifying **whether a provider offers in-person, telehealth only or a hybrid service delivery.** Under the current network directory requirements, Ins. Art. § 15-112(n), the carrier’s directory must identify, for each office of a participating provider, the location, including its address and contact information. To the extent a provider delivers telehealth services, such information should be included as part of the “location” information. **We urge the MIA to require carriers to identify in their network directories whether a provider delivers in-person, telehealth and/or both modes of service delivery and identify the location of the telehealth provider by state and zip code.** This information is critical to consumers seeking MH and SUD care, because, in selecting a provider, many will want to establish a therapeutic relationship with a provider who is able to deliver in-person or crisis services in close proximity.

At a minimum, the MIA should require carriers to gather and include such information for each network participant in its access plan. The MIA has clear authority to require such reporting in the carrier’s access plan, pursuant to Ins. Art. § 15-112(c)(2)(i) and (c)(4)(i) and (d).

II. Content of Access Plan - Sec. 31.10.44.04

We support the proposed enhancement of the data and procedures a carrier must submit annually in its access plan. **We urge the MIA to retain all additional elements** and are particularly supportive of the data reporting requirements on (1) OON service utilization and dollar amount billed and paid for OON services by provider type and geographical region; (2) number and percentage of requests for OON referrals under Ins. Art. § 15-830, carrier determination, and number and percentage of single case agreements; and (3) complaints related to numerous network issues including reimbursement for OON claims and balance billing. We also support the proposed requirement to describe the carrier’s procedures to aid enrollees in securing referral rights under § 15-830 and practices to incentivize providers from Black, Indigenous, and people of color communities to contract with carriers.

A. Additional Data Points

We note that several additional data points would further refine carrier practices related to OON utilization. Specifically, we request that the MIA require carriers to report the following additional information:

- In addition to the number of single case agreements that carriers enter into for OON providers under Ins. Art. § 15-830, **we believe the number of single case agreements that have been requested by members and/or their OON provider is a critical benchmark.** We are aware that providers often seek a single case agreement on behalf of a patient but are unable to enter such agreements because of delayed and unsuccessful rate and contract negotiation. To uncover those trends, the number of single case agreement requests is essential. This data point is consistent with the request for both the number of OON referrals requested and granted.
- To better understand payment practices for single case agreements entered pursuant to Ins. Art. § 15-830, **we urge the MIA to require carriers to report both the average and median in-network contract rate and the average and median OON single case agreement reimbursement rates for the ten most commonly billed services for outpatient and inpatient mental health care, substance use disorder care, and medical/surgical procedures.** We strongly support the proposed provision under (.04)(C)(3)(e)), which would identify billed charges for OON claims and the total amount paid by provider type and geographic region, *yet that data will not uncover payment discrepancies for commonly billed services that affect provider ability to participate in networks.*

Throughout the debate on HB 912/SB 707 during the 2022 General Assembly session, MH and SUD providers explained that low and incomplete reimbursement rates prevented them from accepting network contracts, and carriers asserted that establishing a rate setting formula for OON single case agreements, as proposed under the bill, would disrupt networks and contract negotiations. By gathering this data, the MIA could assess (1) whether contract payment rates for MH and SUD providers are aligned with national rates (e.g., FairHealth data) (2) whether carriers with deficient networks are paying less than national and other carrier rates for network providers and (3) whether the difference between contract and OON payment for MH and SUD services is greater than that for medical services, reflecting a potential Parity Act violation. This carrier data, like other data presented in access plans, is subject to protections for confidential information in access plans. *See* Sec. 31.10.44.10.

- While the proposed regulation requests claims information for OON services when a carrier cannot meet the travel distance metric for 100% of enrollees (.04)(C)(3)(d)(i)), it does not require reporting of the same information when a carrier cannot meet the appointment wait time metric for the proposed 90% of enrollees. **We urge the MIA to include this same reporting requirement for failure to meet the appointment wait time metric, as that is an equally, if not more, common network deficiency.**

B. Access Plan Data Reporting Methodology and Synthesis and Disclosure of Aggregate Data

The proposed data requirements will enhance the MIA's understanding and oversight of carrier network practices and should provide a wealth of information to advance policy making in this context. **To maximize the validity of the data, we urge the MIA to develop uniform definitions, methodologies, and reporting templates for all requested data.** One key lesson from the implementation of the network adequacy regulations over the past five years is that the absence of uniform reporting methodologies and templates has stymied enforcement. To

avoid the submission of non-uniform and incomplete data, we urge the MIA to develop and require the use of standardized data gathering and analysis methods and reporting templates.

Additionally, while plan members would benefit from the inclusion of some additional data in the network adequacy Executive Summary, policymakers *require* access to more granular carrier network information to identify and resolve network adequacy deficiencies. **We urge the MIA to submit annual reports to the General Assembly that summarize key trends related to, among other items, access to and reimbursement of OON services, access to practitioners that deliver culturally and linguistically appropriate services, and policies and procedures that aid members in finding network providers.**

III. Travel Distance Standard - Sec. 31.10.44.05

We support the additional proposed standards for tracking travel distance to providers.

- We particularly support data gathering on the number and percentage of substance use disorder facilities that provide adolescent services as well as the requirement to track access to “residential crisis services.” We request clarification on whether the MIA intends to require reporting of both MH and SUD services under “residential crisis services.” We recognize that “residential crisis services” is defined in the Insurance Article as intensive mental health and support services for those with a mental illness who is experiencing or at risk of a psychiatric condition. (Ins. Art. § 15-840), yet the crisis response system in Maryland addresses both MH and SUD services.
- We continue to question the difference between “drug and alcohol treatment program” and “outpatient substance use disorder facility” and/or “substance use disorder residential treatment facility.” **A “drug and alcohol treatment program” will be either an outpatient or a residential substance use disorder facility and inclusion of all three settings will result in duplicative data gathering that overcounts facilities in the carrier’s network.** As previously recommended, we suggest that “drug and alcohol treatment program” be replaced by “opioid treatment program” to allow for a discrete review of carrier capacity to deliver treatment in these federally mandated facility-based services. Testimony during the legislative debate on HB 912/SB 707 revealed that low reimbursement and limited contract coverage have made it impossible for OTPs to join some carrier networks.

To the extent, the MIA deems a “drug and alcohol treatment program” to be a separate type of treatment facility, please provide a definition of such program, consistent with the provider types licensed by the Behavioral Health Administration, to avoid confusion and duplicative counts.

IV. Appointment Wait Time - Sec. 31.10.44.06

We support the proposed revision that clarifies that the appointment wait time metric and data gathering methodology apply to “in-person” services, **but several proposed revisions to the appointment wait time metric will weaken this standard substantially.**

First, nothing in this standard or the Executive Summary form would require the carrier to report the required compliance metric to members or its satisfaction of those metrics. **In addition to the semi-annual reporting of median wait times by appointment type to**

members, we urge the MIA to require carriers to report the required appointment wait time and the degree to which they have satisfied the standard. While carriers are required to report deficiencies to the MIA (.06(B)(1)), the lack of transparency for member (and others interested in assessing network sufficiency) undermines their ability to understand their carrier’s network and exercise their rights.

Second, the proposed standard would remove the requirement that the median wait time must be met with a participating provider that is located within the applicable maximum travel distance. **We object to the removal of that qualifier because both travel distance and appointment wait time metrics must be satisfied for compliance.** While we understand that the MIA has proposed that telehealth services may be counted for satisfaction of the travel distance metric, the availability of a provider via telehealth does not help an enrollee who seeks an in-person appointment proximate to their residence.

V. Telehealth - Sec. 31.10.44.08

We agree that carriers should be permitted to *count* telehealth visits for satisfaction of network adequacy metrics, as they have for the past 5 years for appointment wait time. We also appreciate the MIA’s effort to (1) craft a “telehealth credit” that seeks to balance the right of consumers to receive in-person services and the interest of carriers to count telehealth services for network sufficiency and (2) require carriers to produce evidence to support a finding that telehealth services are clinically appropriate, available and accessible. That said, **we do not support the proposed standards for both policy and technical reasons.** We note:

- the removal of member election as a criterion for counting telehealth is inconsistent with the fundamental premise that payers, providers and experts all agree upon – “the patient” must be at the center of telehealth utilization for equitable and effective care delivery;
- direct data on enrollee election and clinical appropriateness can be derived, respectively, from tracking patient preferences and appropriately coded claims for service utilization;
- the basis for arriving at the mileage credit is unclear, and no standard is provided for calculating the value (up to 10%) to be awarded for the appointment wait time credit; and
- the draft regulation provides no definition of “clinically appropriate, available and accessible” and the telehealth credit criteria, as drafted, do not consistently require satisfaction of both “availability and accessibility,” which are inextricably linked to enrollee election.

The development of a telehealth credit must take into consideration the lessons learned by Maryland’s providers and payers since the enactment of SB 3 in 2021 and based on broader research.

A. Policy Concerns

1. Patient Needs and Preferences Are the Guiding Tenet of Effective and Equitable Health Care Delivery

The Maryland Health Care Commission’s (MHCC) provider and payer town hall meetings have offered important guidance about the future reliance on telehealth for care delivery. **Both**

providers and payers noted the singular importance and guiding principle of member preference and choice in determining the platform for patient care. This tenet must be central to the policy decision about the inclusion of member election as a factor in the criteria for telehealth utilization to count for satisfaction of network adequacy metrics.

- Providers testified uniformly that the provider and patient must decide the right platform to ensure safe and effective care for the patient, noting that, going forward, the most likely utilization pattern will be a mix of in-person and telehealth care delivery (with some providers and patients seeking only in-person services and some seeking only telehealth).
- The Kaiser Permanente representative testified that the “member needs to be at the center” of the telehealth decision;
- The CareFirst representative agreed that the patient must be central to the decision and that the appropriateness of care is a collaborative decision by the patient and provider; and
- The UnitedHealthcare representative testified that its customer services lay out the options for service delivery, and “it’s still up to the member” as to the best approach.

Research by NCQA also concluded that “equitable and innovative care delivery should always place the patient at the center, thus, the design of technology and digital tools that facilitate care delivery must prioritize patient preference and needs.” NCQA, [The Future of Telehealth Roundtable: The Potential Impact of Emerging Technologies on Health Equity](#) (2022) at p. 10. Individual patient factors and considerations, such as digital literacy, English proficiency, visual, cognitive, intellectual, mobility and functional needs, comfort level with sharing video, and socio-economic status, all contribute to a patient’s care decision. *Id.* at pp. 10 -11.

Similarly, research published by KFF and Epic Research demonstrates that, while a substantial portion of individuals obtained MH and SUD care via telehealth for the period March-August 2021, **over one-half of services were delivered in-person regardless of the specific MH or SUD condition.** Telehealth service delivery accounted for 29% of visits for both opioid and alcohol-related disorders and 33% - 43% of services for a range of MH conditions. Justin Lo, et al., *Telehealth Has Played an Outsized Role Meeting Mental Health Needs During the COVID-19 Pandemic* (Mar. 15, 2022), <https://www.kff.org/coronavirus-covid-19/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/#>. Noting variations in telehealth use by age, geographical location, access to broadband, comfort with technology and digital literacy, the authors advised that “[a]s policy makers continue to look at how to regulate and pay for telehealth services, it is important to consider opportunities for patient choice so that telehealth is not necessarily given as the only option for those looking for care.” *Id.*

Based on this consensus and the evolving development of telehealth services, it is inappropriate to remove the member election requirement from the criteria to count telehealth for metric satisfaction.

At a very bare minimum, the term “clinically appropriate” must be defined to include member election, and the definitions of “available and accessible” must include a consideration of patient choice. While a telehealth service may be available to a consumer in a certain zip code, that does not mean that an individual consumer can access a telehealth service, without considering the individual’s ability, socio-economic means and preference to acquire and use technology.

2. Direct Data on Clinically Appropriate Care and Enrollee Election Must be Gathered and Reported

The adoption of a “telehealth credit” is also misplaced if direct evidence of enrollee election and preference and clinically appropriate telehealth utilization can be obtained. For the 2022 Network Adequacy reports, two carriers, UnitedHealthcare and Kaiser Permanente reported data on telehealth utilization to satisfy its appointment wait time metric. *See* Attachment A. United, for example, relies on claims data to meet the current standard. While we dispute United’s assertion that claims data represent the member’s election of a telehealth service, absent an affirmation of such choice, such data can be coded for telehealth service delivery and should reveal whether the appointment is appropriate for care delivery. *Indeed, claims data is one of the sources of information identified in Sec. 08 as evidence of clinical appropriateness and availability. Sec. .08(D)(1)(c).*

For purposes of enrollee election, there is no reason that all carriers cannot implement electronic tools and member surveys to directly track preferences for service delivery mode. On-line provider directory searches and customer service representatives can readily query members as to their preference for an in-person, telehealth or hybrid provider delivery and then direct the member to the respective provider list that meets the enrollee’s preference. To the extent a carrier operates, endorses or directs members to a telehealth-only platform, it must explicitly provide access to in-person MH and SUD services for members who seek such care, consistent with Ins. Art. § 15-139(c)(1)(iii). Finally, having the provider affirm the enrollee’s willingness to use telehealth would confirm election. This approach appropriately reflects care decisions by members in consultation with their provider as well as accessibility of telehealth and gives appropriate credit to carriers who make telehealth services available.

We urge the MIA to retain the current standard for counting for telehealth utilization and require carriers to submit direct evidence of enrollee election and clinical appropriateness to satisfy travel distance and appointment wait time metrics.

B. Technical Concerns

The proposed “telehealth credit,” if adopted, also raises a number of operational questions. First, we urge the MIA to explain its methodology and rationale for awarding the designated mileage credit on the basis of a clinically appropriate (as expanded to include enrolled election), available and accessible telehealth appointment. An award of five, ten or fifteen miles has no relevance for enrollees who wish to use a mixture of telehealth and in-person care based on their needs and in consultation with their provider. Moreover, if telehealth providers are out-of-state or in a remote zip code from the patient, counting such providers does not address the inaccessibility of services should the enrollee need an in-person appointment for their care. In other words, the criteria for awarding the credit assume *incorrectly* that enrollee willingness to use telehealth services is static. As health care providers testified at the MHCC’s telehealth town hall, most patients will request and require a mix of in-person and telehealth services and their needs will change over time. For example, for individuals who require crisis services to address an acute MH or SUD condition, in-person services in close proximity to one’s place of residence may be the most clinically appropriate service.

For the appointment wait time credit, the proposed rule does not set out the credit percentage value that will be awarded or designate the criteria for determining that value. Essentially, a carrier that meets the in-person appointment wait time metric for only 80% of

enrollees could be deemed in compliance if awarded a 10% credit. As reflected in Attachment A, as of the 2022 reports, all carriers would satisfy the 80% metric for non-urgent MH and SUD services under the current regulatory standards. As with the mileage credit, the availability of a telehealth appointment is of little use if the individual cannot find an in-person appointment in a timely manner.

Second, we recognize that the proposed rule would require carriers to submit evidence of their efforts to assist enrollees in accessing in-person services. *See* Sec. .09(D)(2). While we support those data gathering provisions, the rule does not go far enough to ensure that in-person service delivery option is on par with telehealth services. **First, the proposed regulation *must* require carriers to inform enrollees that they have a right to in-person services within the designated travel distance and appointment wait time either with a network or non-participating provider and include evidence of such notice in its procedures.** This notice is consistent with SB 3, which bars carriers from denying coverage for an in-person MH or SUD service solely because it may be covered through a telehealth benefit. Ins. Art. § 15-139(c)(1)(iii). Extensive discussion during the SB 3 debate focused on consumer choice for service delivery of MH and SUD services, and this provision was adopted to protect that right.

The failure to include this information – particularly in the Executive Summary – elevates telehealth service delivery above patient-centered care delivery, notwithstanding consensus among providers, payers and researchers that the consumer’s choice is central to care delivery. We are particularly concerned about the implementation of carrier telehealth platforms that specifically target MH and SUD services and steer enrollees toward telehealth-only providers in lieu of in-person or hybrid services. Such platforms remove opportunities for meaningful consumer choice and limit continuity of care options if a temporary or permanent transition to in-person service delivery is needed to meet dynamic care needs. Carriers using such platforms must have, at a minimum, robust connections with local service providers to ensure clinically appropriate, available and accessible in-person appointments.

Accordingly, several proposed provisions in Sec. .08(D)(2) should be revised to address the need to ensure the availability of in-person services.

- (D)(1)(b) should be revised to insert a new provision after (ii) – “Telehealth-only platforms for mental health and/or substance use disorder services and procedures for delivery of in-person services.”
- (D)(2) should be revised to insert after “written policies and procedures” the following language: “that inform enrollees of the right to in-person services.”
- (D)(2)(b) should be revised to insert “right to in-person services” before “assistance available....”
- (D)(2)(d)(iii) should be revised to insert “in-person” before “appointment.”

Second, as noted above, the proposed regulation must require the carrier to submit evidence of whether the enrollee elected the telehealth appointment.

C. Premature Adoption of a Telehealth Credit

We are aware of no state that has created a telehealth credit for purposes of satisfying network adequacy metrics. **Several states explicitly bar or restrict reliance on telehealth services to satisfy network adequacy standards.** *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 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).

Additionally, reliance on the use of a telehealth credit in the Medicare Advantage (MA) program is misplaced unless carriers are required to honor a member's request for in-person services, as a condition of claiming a telehealth credit – the operative standard for MA plans. As detailed in previous comment letters, the MA network adequacy standards, 42 C.F.R. § 422.116(d)(5), allow for a 10% credit when “the plan includes one or more telehealth providers that provide additional telehealth benefits, as defined in § 422.135, in its contracted networks for the following provider types....” Section 422.135 only permits MA plans to count these additional telehealth benefits as basic benefits covered under traditional Medicare (which MA plans are obligated to cover) only if they “[f]urnish in person access to the specified Part B service(s) at the election of the enrollee...[and] advise each enrollee that the enrollee may receive the specified Part B service(s) through an in-person visit or through electronic exchange.....”

CMS, in response to concerns raised by providers that the 10% credit for telehealth services could be used to replace, rather than supplement, in-person health care delivery, referenced the above requirements that MA plans must retain consumer choice. CMS also emphasized that it retained the minimum number of contracted providers requirement because it “is imperative for MA plans to be able to provide in-person care when needed or when preferred by the beneficiary and that contracting with telehealth providers as a supplement to an existing in-person contracted network would give enrollees more choices in how they receive health care.” 85 Fed. Reg. 33796, 33856 (June 2, 2020). <https://www.govinfo.gov/content/pkg/FR-2020-06-02/pdf/2020-11342.pdf>

Finally, to the extent a telehealth credit is adopted, **we urge the MIA to require carriers to present the data outlined in Sec. .08 for a full year before any telehealth credit is awarded and to publicly disclose its process and data supporting its award of any credit.** While annual network adequacy reporting is based on the previous calendar year's experience – allowing for a retrospective review of compliance – the adoption of new standards by the end of 2022 will provide, at best, several months of data upon which to base a credit request. **The proposed standard is totally untested and numerous questions exist regarding the implications for enforcement. More data are needed before embarking on this experimental standard.**

VI. Network Adequacy Waiver Standards - Sec. 31.10.44.09

Based on our concerns about the merits of the proposed “telehealth credit,” should such a credit be adopted, **we urge the MIA to require carriers to submit the waiver information set out in Sec. 09, to the extent they rely on a telehealth credit to satisfy network adequacy metrics.** Such information is essential to determine the source of deficiencies and measures that carriers have implemented to address them.

We also believe that penalties for failure to meet network adequacy metrics are an important enforcement tool that would be largely removed if a telehealth credit is awarded to overcome limited in-person availability and access. **We urge the MIA to clarify that penalty provisions will be based on the availability of in-person services should it adopt a “telehealth credit.”**

VII. Network Adequacy Access Plan Executive Summary Form - Sec. 31.10.44.10

We have several significant concerns about the proposed revisions to the Executive Summary Form as it proposes substantial revisions to the reporting of appointment wait time data, which will undermine **transparency** for plan members as well as policymakers and advocates.

First, as noted above, the proposed reporting of median appointment wait times without the percentage of appointments that the carrier has satisfied within the designated wait time, leaves the member in the dark as to the required metric and the carrier's performance. **We urge the MIA to require carriers to report both the median wait time and the percentage of enrollees for whom the metric has been satisfied.**

Second, it is unclear whether the median appointment wait time is based on in-person appointments or in-person and telehealth appointments. The data collection requirement under Sec. 06 gathers the wait time for an **in-person appointment**. **Similarly, the Executive Summary should report median wait times for an *in-person* appointment.**

Third, to the extent the proposed telehealth credit is adopted, the Executive Summary for the wait time metric should, like the travel distance credit, **identify which service types rely on the wait time credit and the calculation without access to the credit. Carriers would be required to report that data in their access plans and that information must be conveyed to enrollees for transparency.**

Relatedly, we object to the inclusion of the proposed statement "that an enrollee may obtain a timelier covered appointment than the median reported wait time for that category if telehealth is elected." This statement may be wholly misleading to enrollees and can inappropriately steer individuals to telehealth services for which the carrier has no in-person service (e.g. appointments through providers that offer only telehealth appointments). As indicated in the provider town hall, the use of telehealth does not necessarily result in earlier or additional appointments with providers that are delivering both in-person and telehealth services. **We urge the MIA to delete this statement and instead require carriers to state in the Executive Summary that enrollees have a right to an in-person appointment within the designated time limits either through a network provider or a non-network provider, consistent with Ins. Art. § 15-830.**

Thank you for considering our views.

AHEC West
Disability Rights Maryland
Institutes for Behavior Resources, Inc.
Maryland Addiction Directors Council (MADC)
Maryland Association for the Treatment of Opioid Dependence (MATOD)
Maryland Coalition of Families
Maryland Psychiatric Society
Maryland Psychological Association
Mental Health Association of Maryland
Montgomery County Council of Parent Teacher Assoc.
NAMI-Maryland
NCADD-Maryland
Courtney Bergan
Laura Mitchell, Member, Montgomery County Alcohol and Other Drug Abuse Advisory Council

Attachment A

ATTACHMENT A

Appointment Wait Time Satisfaction for Non-Urgent MH/SUD Services 2018-2022

Carrier	2018 Report	2019 Report	2021 Report	2022 Report	Telehealth To Meet Appt. Wait Time
Aetna Health Ins.	82% (in 14 days)	89%	72%	NA	
Aetna Life Ins. Co.	82% (in 14 days)	89%	72%	NA	
Aetna Health & Life Ins.	NA	NA	72%	NA	
CareFirst	95%	57.5%	98.1% PPO and HMO	95%	0%
CareFirst BlueChoice	95%	57.5%	98.1%	95%	0%
CareFirst GHMS	95%	57.5%	98.1% PPO and HMO	95%	0%
Cigna Life and Health Ins. Co.	Missing data	76%	100% (POS, OAP, PPO)	94% (POS, OAP, PPO)	0% - No specification of in-person v. telehealth in data gathering process
Connecticut Gen. Life Ins. Co.	Missing data	76%	NA	NA	
Freedom Life Ins. Co.	NA	NA	NA	91%	Telehealth use incorporated via use of claims data.
Golden Rule Ins. Co.	72%	96%	100%	91%	Telehealth use incorporated via use of claims data.
Kaiser Found. Health Plan of Mid-Atlantic States	89.3%	84.3%	Not complete – 1 month count only	94.4%	14.9%

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Kaiser Permanente Ins. Co.	Missing data	28%	80.48%	83.4%	2.2%
MAMSI Life and Health Ins. Co.	72%	96%	100%	91%	Telehealth use incorporated via use of claims data.
Optimum Choice Inc.	72%	96%	100%	91%	Telehealth use incorporated via use of claims data
Optimum Choice Inc. Individual Exchange	NA	NA	100%	91%	Telehealth use incorporated via use of claims data.
United Healthcare Ins. Co. Choice Plus	72%	96%	100%	91%	Telehealth use incorporated via use of claims data.
United Healthcare Ins. Co. (CORE)	NA	96%	100%	NA	
United Healthcare Ins. Co. (Navigate)	NA	NA	NA	91%	Telehealth use incorporated via use of claims data.
United Healthcare Ins. Co. (Options)	NA	NA	NA	91%	Telehealth use incorporated via use of claims data.
United Healthcare of the MidAtlantic Inc. (CORE)	72%	96%	100%	91%	Telehealth use incorporated via use of claims data.
United Healthcare of the MidAtlantic Inc. (Choice)	72%	96%	100%	90%	Telehealth use incorporated via use of claims data.
United Healthcare of the MidAtlantic Inc. (Navigate)	NA	NA	100%	91%	Telehealth use incorporated via use of claims data.
United Healthcare Navigate	NA	NA	100%	NA	
United Healthcare Nexus ACO	NA	NA	100%	NA	

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United Healthcare Options PPO	NA	NA	100%	NA	
Wellfleet Insurance Co.	NA	NA	100% (PPO and OAP)	94% (PPO and OAP)	0% - No specification of in-person v. telehealth in data gathering process