September 9, 2024

Robert L. Carey. Superintendent
c/o Karma Lombard
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333-0034
Karma.Y.Lombard@maine.gov

Re: Proposed amendments to Bureau of Insurance Rule Chapter 850, Health Plan Accountability

Dear Superintendent Carey:

Thank you for the opportunity to provide comments on the proposed amendments to Bureau of Insurance Rule chapter 850, Health Plan Accountability on behalf of Anthem Heath Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield.

- ***Section 1: Purpose***

  The proposed amendment would add pharmacy benefit managers (PBMs) as defined by Chapter 56-C of the Insurance Code. First, this is not a change related to the enactment of P.L. 2921, c. 603 or P.L. 2023, c. 680, and we do not believe the change is necessary or required. However, if the Bureau proceeds with this change, given the breadth of Rule 850, we suggest that language be amended as follows to be consistent with the language of other proposed amendments to the rule and avoid confusion:

  > This rule establishes standards applicable to health maintenance organizations (HMOs), as defined by Chapter 56 of the Insurance Code, utilization review entities, as defined by Chapter 34 of the Insurance Code, pharmacy benefits managers as defined by Chapter 56-C of the Insurance Code ***that conduct utilization review,*** and carriers as defined by Chapter 56-A of the Insurance Code.

  Similarly, we suggest Section 3, Applicability and Scope, be amended to clarify that it is Section 8 of the rule that applies to PBMs that perform utilization review:

  > This rule shall apply to all health carriers, utilization review organizations, ~~*pharmacy benefits managers that conduct utilization review*~~, and managed

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care plans as applicable. Section 7 is applicable to any carrier offering a managed care plan. Section 8 is applicable to any carrier that provides or performs utilization review services, any designee of the carrier or utilization review entity (URE) that performs utilization review functions on the carrier's behalf, *pharmacy benefits managers that conduct utilization review*, and any URE performing utilization review on behalf of an employer. The requirements of section 8 are also applicable to all "adverse health care treatment decisions" rendered by or on behalf of "carriers" offering "health plans," as defined by 24-A M.R.S.A. §4301-A subsections 1, 3 and 7. Sections 9 and 10 are applicable to all carriers. The relationship of the appeals processes set forth in subsections 8(G) and 8(G-1) to the grievance review procedures of section 9 is as follows. All adverse health care treatment decisions denying benefits to a covered person are subject to the appeals procedures set forth in subsections 8(G) and 8(G-1). All requests for review of "adverse benefit determinations," other than "adverse health care treatment decisions," are subject to the grievance review procedures set forth in section 9. In the event of conflict between the provisions of this rule and those of any other rule promulgated by the Superintendent, the provisions of this rule shall be controlling. Any request for confidential handling of filings required by this rule must follow the confidentiality protocol established by the Superintendent and available from the Bureau of Insurance.

- ***Section 5, Definitions***

  - ***Section 5(D)***. Given that actively treating providers were added to the statutory definition of authorized representative in P.L. 2023, c. 680, we suggest revising the definition of appeals procedure as follows:

    "Appeals procedure" means a formal process whereby ~~*a covered person or, a*~~ *an enrollee or an authorized* representative of ~~*a covered person, including an actively treating or attending physician, facility or health care provider on a covered person's behalf*~~ *an enrollee*, can contest an adverse health care treatment decision rendered by the health carrier or its designee utilization review entity (URE), which results in the denial, reduction without further opportunity for additional services or termination of coverage of a requested health care service.

  If necessary, the statutory definition of authorized representative could be incorporated into Rule Chapter 850.

- ***Section 7, Access to Services***

  - ***Section 7(A) and 7(B)***. We recognize and appreciate that the changes to Section 7(A) and 7(B) are being proposed in response to the changes to network adequacy requirements that were contained in Notice of Benefit and Payment Parameters for 2025 issued in April 2024. However, we are concerned that the network adequacy standards and exception process will not be established through rulemaking but instead through the issuance of a bulletin, which does not afford the opportunity for public comment and is not subject to the provisions of the Maine Administrative Procedures Act. We would suggest that these provisions of Rule Chapter 850 sunset on December 31, 2025, and that the

Bureau engage in separate rulemaking to address network adequacy, either further amending Rule chapter 850 in 2025 or proposing a new rule to establish the standards for network adequacy.

- ***Section 7(G)(2) and 7(G)(3).*** The proposed changes to Section 7(G)(2) and 7(G)(3) are not consistent with the language of 24-A M.R.S.A. § 4303(2)(D). For example, 24-A M.R.S.A. § 4303(2)(D), as amended by P.L. 2021, c. 603, does not require that carriers publish what constitutes a complete application on its website.

  With respect to the effective date of credentialing, while a provider may complete the credentialing process, they are not actually participating in a carrier's network until they have returned a signed participation agreement or contract—there can be occasions in which a provider completes the credentialing process but does not execute a participation agreement. The need for this additional language is unclear; however, if it is to be included in the final version of the rule, we suggest amending these paragraphs as follows:

  2) A carrier shall make credentialing decisions*, including those granting or denying credentials,* within 60 days after receipt of a ~~*complete*~~ *completed* credentialing application from a provider. *For the purposes of this paragraph, an application is completed if the application includes all of the information required by the uniform credentialing application used by carriers and providers in this State, such attachments to that application as required by the carrier at the time of application and all corrections required by the carrier. Within 30 days of initial receipt of a credentialing application, a carrier shall review the entire application and, if it is incomplete, shall furnish the provider with a comprehensive list of all corrections needed to make the application complete. A carrier may not require that a provider have a home address within the State before accepting an application. A carrier that is unable to make a credentialing decision on a completed credentialing application within the 60-day period as required shall notify the bureau in writing prior to the expiration of the 60-day period on that application and request authorization for an extension on that application. A carrier that requests an extension shall also submit to the bureau an explanation of the reasons why the credentialing decision on an application is taking longer than is permitted or, if the problem is not specific to a particular application, a written remediation plan to bring the carrier's credentialing practices in line with the 60-day limit.* ~~*If the carrier is unable to make a provider credentialing decision within 60 days, it must apply for an extension on a form prescribed by the Superintendent and provide a detailed explanation of the reason or reasons it is unable to make the credentialing decision within 60 days, or, if the problem is not specific to a particular application, the carrier must provide a written remediation plan to bring its credentialing review practices into conformity with the 60-day limit.*~~ ~~The time period for granting or denying credentials may be extended upon written notification from the carrier within 60 days following~~

~~submission of a completed application stating that information contained in the application requires additional time for verification. All credentialing decisions must be made within 180 days after receipt of a completed application.~~

3) *For the purposes of payment to providers during the pendency of credentialing, t*~~T~~he effective date of credentialing is the date the carrier receive~~s~~*d* a complete application, *provided a participation agreement has been entered into with the carrier.* ~~*A credentialing application is complete completed if the application includes all of the information required by the uniform credentialing application used by carriers and providers in this State, such attachments to that application as required by the carrier at the time of application, and all corrections required by the carrier. The carrier must publish a full list of what constitutes a complete application on the carrier's publicly accessible website. Within 30 days after first receiving the application, the A carrier shall complete its initial review of the entire application and shall either notify the provider that the application is complete or furnish before returning it to the provider for corrections with a comprehensive list of all corrections needed to make the application complete at the time the application is first returned to the provider. A carrier may not require that a provider have a home address within the State before accepting an application.*~~

➢ *Section 8, Adverse Health Care Treatment Decisions*

In 2019, 24-A M.R.S.A. § 4304(7) was amended by P.L. 2019, c. 171 (L.D. 249) to require that an appeal of an adverse health care treatment decision be conducted by a clinical peer. That legislation also amended the definition of clinical peer. Although Rule chapter 850 was amended in 2020 to make conforming changes, an unintended consequence resulted from the change to the definition of clinical peer. Prior to the 2020 changes, section 8(D)(2) required that a clinical peer evaluate the appropriateness of adverse health care treatment decisions or denials. Prior to P.L. 2019, c. 171 taking effect, "Clinical Peer" was defined as "a physician or other licensed health care practitioner who holds a nonrestricted license in a state of the United States, is board certified in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, ***or other physician or health care practitioner with demonstrable expertise necessary to review a case***."[1]

While section 4304(7) requires that an appeal of adverse health care treatment decision be conducted by a clinical peer, no such requirement exists for the initial decision; in fact, such a requirement was specifically removed from L.D. 249.[2] As a result, we propose amending Section 8(D)(2) as follows:

[1] See 24-A M.R.S.A. § 4301-A as enacted by P.L. 1999, c. 742, § 3.
[2] See Section 2 of L.D. 249 as proposed in the 129th Legislature, which proposed to amend 24-A M.R.S.A. § 4304(1) (https://www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0061&item=1&snum=129).

> Qualified health care professionals shall administer the utilization review program and oversee review decisions. A clinical peer *or other physician or health care practitioner with demonstrable expertise necessary to review a case* shall evaluate the clinical appropriateness of adverse health care treatment decisions.

Thank you again for the opportunity to share these comments and please do not hesitate to contact me if you have any questions.

Sincerely,

Kristine M. Ossenfort
Senior Government Relations Director