o

21 August 2017

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

Dear Ms. Larson,

Aetna appreciates the opportunity to offer comments to the Maryland Insurance Administration ("MIA") regarding the recently-drafted network adequacy regulations (the "Regulations"). Although some of our recommendations seem to be reflected in the revised draft language of the Regulations, we do have some additional comments/concerns about specific portions of the Regulations, as outlined more thoroughly below under each identified heading.

.02: Definitions.
"Primary care physician" is defined in Regulation .02. However, Aetna believes it would be more appropriate to use the term "primary care provider" since nurse practitioners can be considered by carriers when evaluating the adequacy of the primary care network. This is supported by the chart in Regulation. 09 delineating the information to be included in the network adequacy access plan Executive Summary that refers to "primary care provider." The definition should read as follows:

"'Primary care provider' means: (a) A provider who is responsible for: (i) Providing initial and primary care to patients; (ii) Maintaining the continuity of patient care; or (iii) Initiating referrals for specialist care. (b) 'Primary care provider' includes: (i) A physician whose practice of medicine is limited to general practice; (ii) A board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist or family practitioner; or (iii) A certified registered nurse practitioner."

The definitions of "rural area;" "suburban area;" and "urban area" discuss "regions" that, according to the Maryland Department of Planning, meet certain specific criteria. Aetna is not sure how "regions" is to be interpreted without a definition. Most, if not all, tools when developing information on network adequacy capture provider and enrollee data by zip code. We recommend the Regulations reflect this.

"Specialty provider" does not include providers that are board-eligible as well as board-certified. We recommend adding the provision to allow providers that are board-eligible to the definition.

As will be discussed when addressing concerns with Regulation .05, Aetna continues to oppose waiting times as a requirement for network adequacy. However, if the MIA continues to include this standard, the "waiting time" definition should be amended. In the current draft of the Regulations, the definition was revised to remove all discussion on preauthorization. This definition does not consider the time the carrier must review and approve the preauthorization request in the calculation of waiting time. For services requiring preauthorization, the definition of "waiting time" should be revised to begin the calculation of waiting time with the date the carrier

has approved the preauthorization request. Aetna suggests the following language be added to the definition of "waiting time" if the MIA chooses to continue to monitor waiting times:

"Waiting time" also includes the time from the carrier's approval of a complete authorization request is communicated to the enrollee until the earliest date offered for the appointment for services.

.04: Travel Distance Standards.

The travel distance charts include several confusing categories that need to be revisited. For "Other Provider Not Listed" and "Other Facilities," we suggest these categories be omitted or, at the very least, be defined with lists of providers and facilities that would be included. We are also concerned that the category "Applied Behavioral Analysis" is included in the charts as it refers to a type of health care service, not a provider. It should be removed from the Travel Distance Standards Charts.

It is not clear how a carrier should measure the travel distance standards. Medicare standards require that at least 90% of enrollees have access to at least one provider in each category as it applies to the defined area type. We recommend that the travel distance standards be revised to be consistent with this Medicare standard. In addition, NCQA also uses access standards that are evaluated from the enrollee's perspective, not simply counting the number of providers.

.05: Appointment Waiting Time Standards.

As Aetna discussed in our previous comments to the Regulations, we are not supportive of establishing appointment waiting time standards. Waiting time standards are inherently difficult for carriers to measure (and for regulators to monitor/audit) due to the fact that these standards generally rely upon physicians to accurately and timely self-report data to carriers or are based on member reports which may also not be accurate. Moreover, our review of similar state network adequacy requirements indicates that waiting times is the least used standard that states have used to determine network adequacy. However, as also stated in our previous concerns with the Regulations, if the MIA continues to include waiting time standards and a chart, Aetna has concerns about the "Non-Urgent Ancillary Services" waiting time standard cited because the term "Non-Urgent Ancillary Services" is not defined and may be interpreted and construed broadly. Thus, Aetna recommends that the MIA expressly define what constitutes "Non-Urgent Ancillary Services" in Regulation .02 or remove the category from the chart.

Aetna is also concerned about holding the carrier accountable for compliance with a standard over which it has no control. Providers establish their own office hours without consultation with the carriers and without knowing the mix of each carrier's enrollees as patients. Providers have no motivation to assist carriers with compliance with the waiting time standards and suffer no consequences for lack of adherence to these standards.

.06: Provider-to-Enrollee Ratio Standards.

Also as stated in Aetna's comments about the previous version of the draft regulations, another standard that is infrequently used throughout the country to measure and/or gauge a carrier's network adequacy is the provider-to-enrollee ratios. The ratio standards set forth in Regulation .06 appear to measure provider-to-enrollee ratios based on the types of services being rendered (i.e. pediatric care, primary care, mental health services, etc.) as opposed to by specific provider types (i.e. Obstetrics and Gynecology). If the MIA chooses to leave these standards in the Regulations, Aetna suggests that the MIA furnish carriers with a list of the types of providers that fall within each type of service category.

.07: Waiver Request Standards.
Aetna recommends that the MIA identify those situations and/or circumstances which the MIA is aware and/or knows may prohibit carriers from complying with the requirements cited in the Regulation and provide carriers with this data. These situations and/or circumstances may include, for example, instances in which the MIA has become aware of the fact that there are no providers of a specific type in a particular geographic area. This may not only alleviate the burden on carriers from identifying such situations and/or circumstances, but also alleviate the burden on the MIA from having to review waiver requests from each carrier concerning such situations and/or circumstances.

.09: Network Adequacy Access Plan Executive Summary Form.
As discussed in our response to Regulation .04, instead of requiring carriers to list the number or percentage of providers in the Executive Summary form that meet the travel distance standards, the standards should reflect the percentage of enrollees that have access to at least one primary care provider and specialty provider in urban, suburban, and rural areas. Each list set out in Regulation .09 should relate to those standards.

Aetna would also suggest that the carrier be allowed to pull out of the Executive Summary form any metric for which the MIA has granted a waiver to the carrier.

If the MIA decides to remove the standards set out in Regulations .05 and/or .06, the corresponding charts and required information should also be removed from the Executive Summary form. Also, as discussed above, if the MIA includes waiting time standards in the Regulations, the "Non-urgent ancillary services" category should be removed as neither the carrier nor the enrollee have any understanding of what these services are.

General Comments.
Aetna is unclear how telehealth services are to be incorporated into the evaluation of network adequacy. How is enrollee access to such services used when determining a carrier's compliance with the standards set forth in the Regulations? Given the growing prevalence and use of telehealth services, Aetna believes that incorporating detailed standards about how telehealth services can and should be considered by carriers when assessing whether their networks are adequate under and pursuant to the Regulations will not only help ensure that carriers are able to meet such standards, but may also minimize the number of waiver requests submitted to the MIA by carriers that may encounter issues and/or concerns complying with the prescriptions of the Regulations. This, inherently, would result in less time required by the MIA to review the waivers and less time required for the carriers to prepare requests for such waivers.

Aetna appreciates the difficult task that the MIA has undertaken in drafting the Regulations and appreciates your willingness to work with all interested parties to develop fair and equitable standards for network adequacy. Although Aetna believes access and adequacy standards will not solve patient access concerns in underserved areas of the state or when there are shortages of specific types of health care providers, we feel as though workable solutions to the concerns expressed in this letter can be developed.

We hope the MIA finds Aetna's comments informative and helpful. Please contact Laura Lee Viergever at 804.873.1116 or viergeverl@aetna.com with any questions you may have or if you need further information.

Sincerely,

Executive Director, Capitol Market

cc: Tinna Quigley
The League of Life and Health Insurers of Maryland, Inc.