UnitedHealthcare®

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August 18, 2017

Via Regular U.S. Mail and E-Mail to networkadequacy.mia@maryland.gov
Lisa Larson
Regulations Manager
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Dear Ms. Larson:

Thank you for the opportunity to provide comments to the Maryland Insurance Administration (MIA) regarding regulations to implement HB1318/SB 929 that will be codified at Title 31, Subtitle 10, Chapter 44 of the Maryland Code. In particular, we appreciate the opportunity to provide feedback to the MIA on the draft network adequacy regulations that were made available by the MIA on July 21, 2017.

1. Sub-section .02(26) –Definitions - Waiting Time

We respectfully submit that waiting time is not a meaningful measure of a carrier's ability to provide access to care. Waiting time depends on many factors largely outside of a carrier's control. For example, appointment scheduling and the setting of office hours by a provider's office are critical factors with respect to waiting time. A carrier, however, cannot control either of these. Further, waiting time can be significantly impacted by the lack of available providers in a particular specialty or geographic area, both of which are beyond a carrier's control. At best, waiting time is an artificial measure of accessibility. For this reason, we urge the Administration to adopt accessibility standards that reflect actual member experience and thereby more adequately capture access. We respectfully submit that measures reflecting member satisfaction with care and member assessment of availability of care more appropriately reflect whether and to what extent care is accessible and urge the Administration to adopt these as standards.

To the extent the Administration decides to retain in the regulations a definition of "waiting time" and accessibility standards related to it, we respectfully submit that the definition should reflect that such period will be measured from the time a carrier renders an authorization of coverage decision for service. Currently, the definition of "waiting time" includes "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." This definition tacitly implies that an initial request will be authorized by a carrier. It does not take into account that a request for coverage may be denied, for example, after a utilization review is conducted. Furthermore, it does not reflect that there are factors beyond a carrier's control that could impact the rate of disposition of a request for services. Pursuant to § 15-10B-06(a) of the Maryland Insurance

Article, an initial determination on whether to authorize nonemergency treatment must be made within two working days of receipt of the information necessary to make the determination (or in the case of an extended stay in a health care facility or additional health care services, such decisions must be made within one working day of receipt of information necessary to make a determination). Carriers do not control the rate of submission by external entities to carriers of all information necessary to make authorization determinations. Such information may be received by a carrier several days or more following an initial request for services. As currently defined in the regulations, "waiting time" will include the amount of time it takes for an external entity to provide to a carrier all of the information necessary for the carrier to make an authorization decision. We respectfully submit that "waiting time" should exclude that period. To the extent that "waiting time" continues to be included in the regulations, we urge the Administration to adopt a definition that reflects that such period does not begin until after a carrier renders an authorization decision following the initial request for health care services by an enrollee or by the enrollee's treating provider.

2. Sub-section .03(A) – Filing of Access Plans and Sub-section .09 – Network Adequacy Access Plan Executive Summary Form

The draft regulations reflect a due date of July 1, 2018 for a carrier to submit a first access plan filing and then on July 1 annually thereafter. The regulations also delineate the information required to be included in the access plan and the attendant executive summary form. We continue to respectfully request an opportunity to engage with the MIA in the development of the format and form of the access plan that carriers will be required to submit. We are especially interested in guidance regarding the acceptable electronic format of the submissions. We believe that collaboration in this regard will result in the production of an access plan format and form that can be efficiently completed and timely submitted by carriers.

3. Sub-section .04(A)(4) – Travel Distance Standards - Sufficiency Standards

The chart of provider/facility types and geographic area distance requirements includes the categories "Other Provider Not Listed" and "Other Facilities." We respectfully submit that clarification is needed concerning the types of specialties that will fall within these catch-all categories and how compliance will be monitored and enforced by the MIA. The chart also includes "Applied Behavioral Analysis" among the categories of facilities. We respectfully submit that this category should be removed because Applied Behavioral Analysis is not a type of facility.

4. Sub-section .04(C)– Essential Community Providers

We respectfully submit that parity between the Federal and State standards promotes market efficiency and submit that a 20% (rather than a 30%) threshold for Essential Community Providers should be reflected in the regulations. The Centers for Medicare and Medicaid Services recently lowered the standard for Essential Community Providers from 30% to 20% (*see* copy of CMS Market Stabilization Final Rule at https://s3.amazonaws.com/public-

inspection.federalregister.gov/2017-07712.pdf). We urge the Administration to adopt regulations that promote parity between the Federal and State standards.

5. Sub-section .05 – Appointment Waiting Time Standards

We recognize and appreciate the Administration's inclusion of language in subsection .05(A)(2) concerning a carrier's ability to consider the availability of telehealth providers to meet accessibility standards when an enrollee elects to utilize a telehealth appointment. However, the assessment of accessibility that is triggered only when an enrollee elects to use telehealth providers just partly recognizes enrollees' full accessibility to health care services. The ability of a carrier to meet accessibility standards through telehealth providers should not be limited solely to when an enrollee elects to receive care in that manner. The availability of telehealth providers to offer clinically appropriate care exists notwithstanding a choice to utilize these providers. Consequently, we urge the Administration to adopt regulations that allow carriers to use without limitation the availability of telehealth providers to meet accessibility standards. We urge such consideration to the extent that the Administration decides to retain in the regulations a definition of "waiting time" and the accessibility standards related to it.

6. Sub-section .07(C) – Waiver Request Standards

We fully support the inclusion of waiver request availability in the regulations. The required disclosures in such requests potentially could encompass confidential and proprietary provider contract material and terms as well as confidential information regarding future contracting efforts. Carriers generally do not make such information publicly available, in part, because of its value to competitors. For this reason, we respectfully submit that the information included in a waiver request be designated confidential by the Commissioner and not subject to disclosure under the Public Information Act.

We again appreciate the opportunity to provide comments on the draft proposed network adequacy regulations and look forward to the MIA's consideration of our observations. Please feel free to contact me at 240-683-5374 if you have questions concerning our comments.

Sincerely,

John Fleig
Chief Operating Officer
UnitedHealthcare of the Mid-Atlantic, Inc.