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

Dear Ms. Larson:

Cigna appreciates the opportunity to provide feedback on proposed regulation 31.10.44- Network Adequacy. We respectfully offer these comments for your consideration.

Broad concerns and considerations

Generally speaking, geographic standards are the most prevalent network adequacy measure in the country. As noted in the research provided by the University of Maryland, Carey School of Law, only 21 states – less than half of the country- utilize some iteration of geographic standards measure; Further, only nine states utilize provider ratios and only 12 states utilize appointment wait times as measures. Of these measures, the application of appointment waiting times to non-group model HMOs is troubling, as traditional health plans do not exert the same type of control over providers that a group-model HMO may. Traditional PPOs do not have access to provider scheduling information and are not provided patient level data from providers about their scheduling time frames. While carriers routinely include requirements to schedule patients timely in provider contracts, dismissal from the network is the only recourse with a non-compliant provider. It remains unclear how a carrier would be able to measure and report this information accurately to the MIA or how the MIA would audit this metric. It seems the only way such a measure would ever be effective would be in conjunction with a requirement that providers gather this information per payor and report it back to a payor for the payor's patient population. Otherwise, anecdotal evidence of questions or complaints from enrollees becomes the only known measure.

The MIA has worked to take into consideration the application of standards to varying delivery models. We believe the MIA should look more closely at how this standard would be implemented for traditional plans versus group-model HMOs. We strongly urge the MIA to consider removing this measure or applying it only to plans who have direct control of their

provider groups and can effectively measure wait times. Ultimately, should the MIA adopt standards that inadvertently advantage or disadvantage plans in the State by creating an inaccurate picture of the network's adequacy for enrollees, the impact on the market could be significant.

I will address specific provisions of the regulations in the order in which they appear.

.02 Definitions

1. (19) "Rural area" and (24) "Urban area"- While we appreciate the definitions attempt to give guidance about what constitutes the rural and urban areas of the State, we would urge the MIA to identify the areas specifically (county, zip code) and advise plans of those determinations to ensure that all plans are using the same boundaries and any comparisons are made on an apples to apples basis.
2. (26) "Waiting time" – This definition should read "the time frame from the request for an appointment for services by an enrollee or an enrollee's treating provider and the earliest offered date for the appointment for services." As currently drafted, this definition could be read to include the time during which a pre-authorization request has been made. Preauthorization requests or prior authorization requests are requests for the approval of services. They are not necessarily related to the timing of the request for the *provision* of services. A patient's physician can set the appointment at the same time as making the prior authorization request, after choosing to wait for the response, or after setting the appointment, as appointments can be cancelled. Without this requested clarification, the definition makes calculation of the time frame difficult and creates an odd confusion of what is being requested of a carrier in a prior authorization and what is being requested of a provider in an appointment request.

.04 Travel Distance Standards

1. The regulation creates separate standards for non-group-model HMOs and group-model HMOs. It is unclear why there should be different standards for group-model HMOs for contracted providers outside of the group-model HMO's medical group. In that case, it seems that the standards applicable to the rest of the industry should apply. It appears the MIA may be attempting to parse out providers or facilities it believes are within the group-model HMOs network. However, to establish the right level of parity and avoid disadvantaging any segment of the market, it would be easier to simply apply the same standards for all contracted providers, including those servicing a group-model HMO without attempting to parse out specific categories of providers or facilities.
2. We urge the MIA to rethink the approach taken regarding primary care. Currently, the chart uses the term "primary care physician." Section A(2) of the regulation, however, broadens this term and allows that "when-an enrollee elects to utilize a gynecologist, pediatrician or certified registered nurse practitioner for primary care, a carrier may

consider that utilization as a part of meetings its standards" for primary care. We appreciate the MIA acknowledging that there are a variety of providers that perform primary care services for enrollees. However, given that these geographic standards are calculated without looking at the specific services accessed by specific enrollees, the approach taken in 31.10.44.04A(2) is impractical. It requires a level of enrollee by enrollee review that makes the calculation difficult. We urge the MIA to use the term "primary care provider" instead of physician and include certified registered nurse practitioners within that definition. It seems incongruent for Maryland insurance law to require the reimbursement of all licensed and certified providers operating within their scope of practice but not allow carriers to include these providers in their network metrics for purposes of meeting network adequacy standards. Broadening the category to "primary care provider" aligns the requirement with the real world and acknowledges the various, appropriate ways patients access primary care.

3. We urge the MIA to reconsider the standard for licensed clinical social workers. These valuable providers are extremely challenging to recruit into the network. A "Masters' level licensed therapist" may provide additional options to carriers to meet patients' needs. Again, this limitation prohibiting the inclusion of appropriate providers operating within their scope of practice for purposes of network adequacy seems incongruent with Maryland's requirement to reimburse all licensed and certified providers operating within their scope of practice. Broadening the range of included providers will help increase in-network access in a specialty area where shortages can occur.
4. The standards do not take into account the role telehealth can play in providing access to care. As the State of Maryland has pushed forward legislatively to require carriers to cover telehealth services as an innovative way to expand provider capacity and improve quality while reducing the need for patients to travel long distances and or wait for long periods of time to get care, it is our hope that these regulation will not serve to lock Maryland into a single approach to patient care. Carriers should be permitted to include telehealth access for appropriate services as part of meeting a geographic standard, particularly where provider shortages by specialty or geography exist.
5. The regulation includes "applied behavioral analysis" under facility. Applied behavioral analysis is a service and is neither a provider type nor a facility. For this reason, we believe it should be removed from the list entirely.
6. The inclusion of the broad yet undefined catchalls of "other providers not listed" and "other facilities" is problematic. Given that Maryland has proposed a very specific list of providers and facilities unlike most other states, these broad terms seem unnecessary. If they are retained, we urge the MIA to provide definitions.
7. Section .04(C) requires carriers to include 30 percent of the available essential community providers in its network. In Section 156.235 of the recently adopted market stabilization rules, the U.S. Department of Health and Human Services acknowledged the 30 percent threshold for essential community providers as too stringent a standard

and reduced it to 20 percent of available essential community providers in the final rule. The previous threshold was problematic in Maryland as it was in other states. Cigna supports the federal standard and respectfully recommends that Maryland follow the federal standard.

8. The proposed regulations attempt to address tiered plans. Tiered or select networks may be "narrow" and offer fewer, but still high quality, providers and choice for a reduced cost or more favorable cost sharing as an incentive. Applying the same standards to all networks has the effect of eliminating a plan's ability to introduce tiered networks in Maryland. If the regulations were effectively apply to plans utilizing a narrow network, the more appropriate approach would be for the regulations to allow an alternate, less stringent standard applicable to the plan with the lowest cost sharing in a tiered plan, provided the carrier demonstrates that network continues to meet the needs of enrollees and, per the NAIC Model Act, is not discriminatory. As drafted, a carrier offering a select network would have to meet more stringent standards in their broad access plan than their competitors, while meeting the same standards for a select plan as their competitor's broad access plan. This is an untenable way to design such a product and will have an impact on the new products and innovations plans can introduced in Maryland as opposed to other states. We urge the MIA to rethink this approach and the practical impact it will have on network innovation in the State. We would be happy to discuss this point with the MIA further based on our experience with select network design.

.05 Appointment Wait Time Standards
We reiterate our concerns with the inclusion of wait time standards in the regulations.

.06 Provider-to-Enrollee ratios
We are unclear as to the policy that supports excluding group-model HMOs from the provider-to-enrollee ratios. It would seem that the fact that the providers are employed by the group-model HNO does not negate the need to have a sufficient number of providers in the network relative to the number of patients. Unlike geography, which can be impacted by the model, we do not believe the delivery model alters the patient's needs. We would suggest altering the applicability of this provision.

.07 Waiver request standards
To reduce the burden on the MIA and plans, we suggest that, when clear demonstrated provider shortages are known in the State by specialty or geography the MIA should notify carriers of the shortage and adjust the required standards accordingly rather than require each carrier to file for a waiver.

.09 Network Adequacy Access Plan Executive Summary Form

1. In Section A(1)(a) regarding travel distance standards, the data is to be reported as "the percentage of participating providers….for which the carrier met the travel distance standards…." NCQA requires a similar metric of carriers but frames it as the percent of members who have access to that provider type under the standard. Given that the standard is the travel distance experienced by the patient, this approach better reflects the standard under Regulation .04 and allows carriers to continue to calculate the data as occurs today under NCQA.
2. In Section A(2)(a) regarding appointment waiting times, the data is to be reported as the "percentage of appointments…for which the carrier met the appointment waiting time standard…." Given that most carriers will have little to no hard data on patient wait times, it is unclear how carriers are anticipated to calculate and report this metric. Without a requirement that providers provide carriers the specific data for their enrollee population, carriers will be simply unable to report this data. If this metric were to remain, allowing carriers to use consumer survey data such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey would give carriers accessible data that could be reported. However, the wait time questions in the survey do not align with the measures included in the regulation, nor do they capture responses from the required 95% patent threshold. Should the MIA be willing to allow survey data to demonstrate the wait time experience of enrollees, we would urge aligning the metric with the questions and sample size in the CAHPS survey.

Thank you for your time and consideration of these comments to the draft proposal. Please contact me with any questions at 860-907-6396 or Kimberly.Robinson@cigna.com.

Sincerely,

Kimberly Y. Robinson

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Director, Regulatory and State Government Affairs