8 May 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 a number of our recommendations seem to be reflected in the 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 Section heading of the Regulations.

Section .02: Definitions.
When developing the definitions for "large metro areas," "metro areas," "micro areas," and "rural areas" set forth in Section .02 (and used in Section .04 concerning the geographic accessibility of providers) it appears as though the MIA tried to define these terms through the use of human population density metrics – thereby defining terms such as "micro area," for example, as a county or independent city with a human population of (a) 50,000, but less than 200,000, and a population density that is at least 10 per square mile, but less than 100 per square mile; or (b) 10,000, but less than 50,000, and a population density that is at least 50 per square mile, but less than 1,000 per square mile.

However, in order to have consistency amongst carriers as to which counties/independent cities fall within each type of metro area (i.e. large, metro, micro or rural), Aetna recommends that the MIA provide carriers with a list of the specific Maryland counties/independent cities that would fall within each type of metro area.

Next, there is a definition of "telemedicine" included in this Section of the Regulations that is not used anywhere else throughout the Regulation. Aetna suggests retaining this definition or adding a definition of "telehealth" and adding language to the Regulation about how telemedicine/telehealth and other innovative delivery system options can be used to support an adequate provider network.

Lastly, Aetna recommends amending the last sentence of the definition of "waiting time" as follows:
"Waiting time ***also*** includes the time ***from the carrier's receipt of a complete authorization request until the carrier's initial decision on the authorization request is communicated to the member*** ~~for obtaining authorization from the carrier or the carrier's participating providers for the appointment~~."

Section .03: Filing of Access Plan.
Aetna recommends requiring all carriers to file an initial network access plan by July 1, 2018. However, for subsequent calendar years beginning on July 1, 2019, Aetna recommends amending the Regulations to include a provision which allows each carrier to file a notice certifying to the MIA that the carrier does not have any material changes to report to the carrier's filed access plan, as appropriate. Aetna believes that this may reduce

the administrative burden on both carriers and the MIA to prepare and/or review access plans that may include information that is either redundant and/or repetitive of information currently on file with the MIA.

Please note, however, that further review of the actual network access plan template will be necessary in order for Aetna to comment on the specific data elements contained therein. Aetna is hopeful that the development of the template can be a collaborative project between the MIA and the carriers.

Section .04: Geographic Accessibility of Providers.

The distance requirement charts cited in Section .04 concerning the geographic accessibility of providers include a mix of specific provider types (*see, e.g.* Dermatology and Primary Care Physician) and specific types of health care services (*see, e.g.* "Cardiac Surgery Program") that carriers must maintain within their network. Aetna recommends amending this list to only include providers. Any expressly identifiable health care service (*e.g.* Cardiac Surgery Program and Critical Care Services) should be identified under the type of provider that the MIA expects and/or anticipates should be able to render such services.

We would also recommend paring down the list of providers/services to those most utilized.

Next, Subsection C. of Section .04 requires that a carrier have 30% of the available Essential Community Providers ("ECPs") in each of the carrier's defined rating areas. The Centers for Medicare and Medicaid Services ("CMS"), however, currently only requires each carrier to have 20% of the available ECPs in each of the carrier's defined rating areas. For consistency, Aetna recommends that this Subsection be revised to mimic the ECP requirements issued by CMS.

Lastly, in order to measure network adequacy effectively, carriers must know the complete universe of Maryland health care providers by location and specialty. The MIA should make this available to all carriers.

Section .05: Waiting Times for Appointments with Providers.

As Aetna discussed in our previous comments to the Regulations, we are not supportive of establishing appointment wait time standards. Wait 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 wait-time related data to carriers. Moreover, our review of similar state network adequacy requirements indicates that wait times is the least used standard that states have used to determine network adequacy. However, if the MIA continues to include a waiting time standard chart, Aetna has concerns about the "Non-Urgent Ancillary Services" waiting time standard cited due to the fact that the term "Non-Urgent Ancillary Services" is not defined and may be interpreted and construed broadly. Thus, Aetna recommends that the Administration expressly define what constitutes "Non-Urgent Ancillary Services" in Section .02 ("Definitions") of the Regulations

Section .06: Provider-to-Enrollee Ratios.

As another standard that is infrequently used throughout the country to measure and/or gauge a carrier's network adequacy, the provider-to-enrollee ratios set forth in Section .06 of the Regulations 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.

Section .07: Waiver Request Requirements.
Without reviewing a copy of the waiver request form cited in Section .07 of the Regulations, we are unable to provide complete feedback on the provisions of this Section. Aetna, however, nevertheless recommends the use of certain factors in the MIA's review and consideration for approval of any waiver requests submitted by each carrier, including, but not limited to, provisions for the use of physician extenders, centers of excellence, the use of telemedicine/telehealth services, and other innovative ways to deliver appropriate health care services.

Aetna suggests the removal of Subsection 2 of Section .07 in its entirety. Requiring carriers to make these waiver request forms available to certain providers creates issues with confidentiality and contract negotiations. In addition, we are not sure what the MIA's intent is by the inclusion of this language in Subsection 2.

Section .08: Confidential Information in Access Plans.
We are concerned that the waiver request form is not part of the information that the carrier can request the MIA maintain as confidential. Aetna recommends including the waiver request form in the confidentiality provisions of this Section of the Regulations. Also, until we review the information required to be contained and/or provided in both the network access plan template and the waiver request form, we may have concerns about what information contained in these documents can and should be made available to the public.

General Comments.
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: Kim Robinson
The League of Life and Health Insurers of Maryland, Inc.