December 4, 2020

Lisa Larson
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 revised draft network adequacy regulations. Our comments/concerns about specific portions of the revised draft regulations are outlined more thoroughly below under each identified heading.

***.02 Definitions*:**
Aetna does not have specific concerns regarding the actual definitions added or changed. The concerns are more about the context in which these defined entities or defined terms are used throughout the revisions.

.03 Network Adequacy Standards:
Aetna has concerns about both the granular nature of the provider listings and the frequent monitoring of the required standards. Many contracted providers have multiple specialties and multiple offices. By requiring providers be listed by zip code and then specialty, there will be much duplication and confusion as many providers will be listed many times. We already have providers broken out by general specialties and members can search our directory by zip code. The proposed new requirements in the revised draft regulations go beyond what we are currently doing while providing little additional value to members. We suggest requiring that carriers have provider listings which includes provider specialties and zip codes. This information can be filtered and searched to assist members in locating the appropriate provider to suit the member's specific needs.

There are a number of specialties and sub-specialties listed which include types of providers that are not included in some carriers' large group policies. Our recommendation is to require a carrier to develop and maintain a network of providers adequate to deliver the full scope of covered services, including, as appropriate, the listed providers

The provider network does not change significantly from one month to the next. Monitoring the network for compliance monthly is an unnecessary administrative burden on the carrier that provides little value to members. We suggest removing it.

In addition, what is the purpose or expected benefit of requiring the carrier to create a quarterly member out of network claim cost report? This will lead to additional

administrative cost that will ultimately be passed on to our members. We recommend removing this requirement.

***.04 Access Plan Filing*:**
Aetna's network providers self-report what languages and cultures are represented in their practices. As a result, it is difficult to obtain detailed, definitive information, especially as it will require providers to take time away from treating patients to be able to be responsive to additional administrative requirements. Carriers will bear the regulatory burden of compliance when it is beyond their control what language and cultural needs are met at each participating provider practice.

Carriers and providers strive to meet the physical, language, and cultural needs of their members and patients; however, requiring member surveys to determine these needs is problematic. In our experience, member surveys typically result in low response rates. This low response rate may be due, in part, to members feeling that they are being profiled or discriminated against by disclosing this information to us when, in fact, the intent is the opposite. We recommend the requirement be for carriers to make best efforts to work with providers to accommodate members' physical, language, and cultural needs. Documentation to demonstrate these efforts could include policies or contract provisions related to these accommodations.

Members typically do not have control over which hospital-based or on-call providers they see when in the hospital. The revised draft regulations require carriers to report whether any non-physician providers, who routinely provide services to patients, are not participating providers. Carriers would need to request the information from participating hospitals and a carrier's ability to comply with this requirement would be dependent on hospitals providing timely and accurate information. We recommend removal of this requirement as, again, carriers will bear the regulatory burden of compliance when it is beyond their control.

***.05 Travel Distance Standards*:**
Aetna is concerned about the new requirement to determine provider access using public transportation in areas that rely on this. Information on bus and train routes as they compare to provider practice locations are not readily available. In areas where transportation is a concern or members cannot drive to their provider visits, carriers have developed options such as telehealth visits and vouchers or payment for ride share services like Uber or Lyft to overcome member access barriers. We would recommend a more open-ended commentary on how carriers can offer members access to providers to meet the travel distance standards, instead of being restrictive to simply discussing public transportation options.

It also appears that the carrier is expected to have 100% compliance in each urban, suburban, and rural area in Maryland in which it is licensed to do business for all 46 provider and facility types unless it requests a specific waiver for any of these for which there is not 100% compliance. There are many reasons that carriers may not meet these travel distance standards for all provider/facility types in all parts of the state including lack of specific provider types. Carriers have recommended an 80% overall compliance level for the state (similar to WA), not each locality, and requested that there be blanket exceptions in areas

where there is a specific provider shortage. In addition, carriers should be able to use telehealth to accommodate members when there is a lack of specific provider types in a certain locality with a compliance credit allowed. (similar to what CMS allows for Medicare Advantage plans.)

Aetna has expressed concern in the past related to travel distance standards for Outpatient Infusion/Chemotherapy facilities. The MIA changed this to Ambulatory Infusion Therapy Centers; however, this does not accurately reflect how members receive infusion services since these can be performed in a number of settings including inpatient, outpatient, and at home. Therefore, we recommend that this type of facility be removed as a separate category.

Essential Community Providers:
Instead of requiring at least 30% of the ECPs in the state of Maryland, the requirement is revised to be at least 30% in each urban, rural, and suburban area for mental health and substance use disorder ECPs. Again, this is a change that may require significant additional resources. We recommend that no changes be made to the current regulations regarding Essential Community Providers.

***.06 Appointment Waiting Time Standards*:**
Do the urgent care inpatient and outpatient medical services and urgent care inpatient and outpatient mental health and substance use disorder services include emergency services? We are not clear about what you consider urgent care behavioral health facilities. The regulations should clarify whether urgent care includes emergency services.

The draft revised regulations do indicate that telehealth visits can be considered when determining compliance with appointment wait time standards but there is no explanation of how this can be considered. We recommend inclusion of the use of telehealth to comply with appointment waiting time standards.

As we previously stated, responses to member surveys are typically very low. Member survey tools are also very subjective. Expecting quarterly responses that meet the specific survey calculation requirements is very optimistic and sets the carrier up for non-compliance. Members will be asked to complete surveys about physical, language, and cultural needs as well as wait times, all of which may cause member abrasion. In addition, member reporting of wait times are unreliable and subjective and do not offer helpful information. Finally, providers have the control over their office hours and patient load, not the carrier, but again the carrier would bear all the regulatory burden on this issue.

It is also concerning that carriers will be surveying providers on a quarterly basis regarding appointment wait times. Providers that participate with multiple carriers will be contacted by each of the carriers to respond, taking resources away from treating patients. We believe this will lead to abrasion in the provider community.

NCQA allows statistical sampling for wait times that are lower than the proposed requirements for calculating and monitoring wait times. This is what carriers currently use; carriers will require significant additional resources to comply with the new requirements

set out in the draft regulations. Therefore, we recommend that the regulations remain consistent with NCQA requirements for statistical sampling.

Through no fault of the carrier, compliance with these wait time standards using these subjective quarterly requirements for calculation will be difficult. In addition, notification to the MIA within 10 business days if a carrier fails to meet 90% in each appointment type wait time category accompanied by an explanation of efforts taken to so comply may prove to be too frequent and very burdensome to both the carrier and the MIA, especially considering the limited value of this information.

As discussed on the call with League members and the MIA on December 2, 2020, wait times appear to be a metric that is of interest to consumers; however, provider practices are the ones that would have this information. It would be most helpful for providers to publish wait times which should be uniform across carriers instead of having carriers survey members and providers, both of whom would be providing very subjective and non-comparable information. So that consumers would be able to obtain accurate, comparable wait time information, we would recommend the MIA meet with MDH to discuss having providers disclose such information annually.

***.08 Network Adequacy Waiver Standards*:**
Since the revised draft regulations require 100% or nearly 100% compliance with most of the very frequently assessed and difficult standards, the waiver requests and reviews will be extremely labor-intensive for both the carriers and the MIA. There is concern that this may not be beneficial to the member. As previously mentioned, Aetna recommends lowering the compliance requirements.

***.09 Confidential Information in Access Plans*:**
This section has been revised to replace references to "Methodology" with "Propriety Methodology" regarding information in an access plan that is considered confidential. This creates ambiguity to what methodologies are considered confidential and may result in carriers' methodologies being made public even if they are not what may be considered a standardized methodology. Aetna recommends that this section not be revised.

***General Concerns*:**
Finally, Aetna has several general concerns regarding the proposed revisions:

- These draft revisions significantly increase the network adequacy standards and will require more resources with the result of costs being passed on to the member with little value created in return.
- More frequent reporting requirements will also require an increase in MIA resources to monitor these reports with little additional value.
- There is no "skin in the game" for providers to participate with the carriers or for providers to comply with wait time standards. Carriers do not control these factors but will nevertheless face consequences for non-compliance.
- Network access and travel distance standards do not consider provider shortages either due to access difference across the state or due to the type of provider. There

should be some acknowledgement of these shortages and allowances for them when considering compliance.

- The expected effective date of these revised standards has not been communicated. Many of these revisions will require significant resources and take an extended period of time to implement. Aetna would suggest that, at the earliest, any revisions take effect for the 2022 network adequacy filings that will be submitted by July 1, 2022.

Aetna appreciates the difficult task that the MIA has undertaken in attempting to revise the existing regulations and appreciates your willingness to work with all interested parties to develop fair and equitable standards for network adequacy. Unfortunately, Aetna believes these access and adequacy standards will not solve your patient access concerns in underserved areas of the state or when there are shortages of specific types of health care providers. We believe there are other workable solutions to the concerns expressed in this letter that could be developed. We also believe the provider community needs to be a more active player in this.

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,

Michael Bucci
President, Capitol Market

cc: Matthew Celentano
The League of Life and Health Insurers of Maryland, Inc.