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Mid-Atlantic Permanente Medical Group, P.C.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

October 17, 2017

Nancy Grodin, Deputy Commissioner
Bob Morrow, Associate Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Re: Proposed Regulations *COMAR 31.10.44 Network Adequacy, Section .04(C)* related to Essential Community Providers

Dear Ms. Grodin and Mr. Morrow:

Thank you for meeting with representatives of Kaiser Permanente on September 22 to discuss our comments on proposed *COMAR 31.10.44 Network Adequacy*. We have proposed the following option for an Alternate ECP Standard for group model HMOs.

Alternate ECP Standard for Group Model HMOs

As we have discussed, much of the value of our integrated delivery system comes from having highly integrated information systems, shared clinical protocols across our providers, and thorough monitoring and management of all patient information. Requiring Kaiser Permanente to contract with non-Kaiser providers to meet the ECP standard that applies to other carriers would fundamentally change how we structure our delivery system and would undermine the ability of our integrated care teams to provide consistent, high-quality care to our patients. Such contracting would also increase costs, leading to higher member premiums.

For the MIA's consideration, Kaiser Permanente offers the following amendment for an Alternate ECP Standard for group model HMOs. Consistent with our previous advocacy, we believe the amendment which is based on quality measure performance, provides a more compelling view of access to care for members whom the ECP policy is intended to serve by demonstrating that members in low-income areas or Health Professional Shortage Areas (HPSAs) are receiving important health care interventions, thereby demonstrating access to care.

HEDIS Measures Demonstrating Access to High-Quality Care

- **Proposed Amendment to Regulatory Language:**

  C. *Essential Community Providers.*
  (1) Each plan *that is not a group model HMO plan* shall have 30 percent of the available essential community providers as part of its provider panel in each of the defined rating areas.

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(2) Each group model HMO plan shall demonstrate that its own providers located in Health Professional Shortage Areas or low-income zip codes within its service area perform at or above the 50th percentile on three HEDIS measures:

(a) Controlling High Blood Pressure;

(b) Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment; and

(c) Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults.

- **Discussion and Rationale:**

Kaiser Permanente recommends that the MIA adopt the following three Healthcare Effectiveness Data and Information Set (HEDIS) measures for purposes of group model HMOs meeting the Alternate ECP Standard: Controlling High Blood Pressure (CBP); Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET); and Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS). These measures are used nationally and have been validated by the National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF).

We also recommend that the MIA set a performance target for group model HMOs at the 50th percentile, meaning that the group model HMO performs above the average for all carriers nationwide (for the entire commercial population). To measure performance for purposes of the Alternate ECP Standard, we would limit the population to our providers and members located in HPSAs (the low-income and vulnerable populations intended to be served by ECP standards generally).

High performance on these measures demonstrates that individuals intended to be served by the ECP policy are in fact accessing care—in contrast to availability measures that only demonstrate hypothetical access. Furthermore, performance above the national average (50th percentile) demonstrates that members are receiving high-quality care. It is broadly recognized that people in low-income areas/HPSAs tend to be more challenging for health delivery systems to manage than the general population due to social determinants of health. By applying the selected HEDIS measures and tracking them at the 50th percentile, group model HMOs will demonstrate that these vulnerable patient populations have good access to high-quality care, which is the essence of measuring network adequacy.

1. Controlling High Blood Pressure (CBP)

We recommend the hypertension control measure because hypertension impacts a large portion of the at-risk population. The CBP measure is reported as follows:

> Patient population/denominator: Ages 18-85 with an outpatient diagnosis (one encounter or claim) of hypertension during the first 6-month period of the measurement year.
>
> Compliant/numerator: Number of patients, in the population, whose last blood pressure during the measurement year was in control based on the following:

- Members 18-59 years of age whose Blood Pressure (BP) was ≤139/89
- Members 60-85 years of age with two dx of diabetes whose BP was ≤139/89
- Members 60-85 years of age without two dx of diabetes whose BP was ≤149/8

2. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

Given the MIA's focus on substance abuse, we believe the IET measure is appropriate to report for population intended to be served by the ECP policy. IET measures the percentage of diagnosed alcohol- or drug-dependent patients who began treatment within 14 days of the diagnosis.

Patient population/denominator: 13 years or older diagnosed with Alcohol or Other Drug (AOD) dependence during an inpatient, intensive outpatient, partial hospitalization, outpatient, telehealth, detoxification, or emergency department encounter.

Compliant/numerator: Patients who have an in-person encounter with any provider, online assessment, or telephone visit with a diagnosis matching the index episode start date (IESD) diagnosis cohort, or if the index episode was for a diagnosis of alcohol/opioid abuse or dependence, a medication assisted treatment event for alcohol/opioid within 14 days of qualifying diagnosis.

3. Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS)

Given the MIA's focus on mental health, we believe the DMS measure is appropriate to report for the population intended to be served by the ECP policy. As this is a first year HEDIS measure, we recommend submitting actual performance in the first year of this measure and then tracking to the 50th percentile for the second year.

Patient population/denominator: Ages 12 or older diagnosed with major depression, depression in remission or dysthymia in a face to face encounter in past 12 months.

Compliant/numerator: Eligible population who have a PHQ-9 (Adult or Teen) administered at least once during the 4-month assessment period in which they were diagnosed:

- Assessment Period One: January 1st - April 30th
- Assessment Period Two: May 1st - August 31st
- Assessment Period Three: September 1st - December 31st

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We thank the MIA for considering the important differences in how group model HMOs provide access to care and for your willingness to include an Alternative ECP Standard for group model HMOs in the network adequacy regulations to ensure that Kaiser can continue to provide high-quality care and coverage to Maryland residents.

Please feel free to contact me at Laurie.Kuiper@KP.org or 301.816.6480 if you have any questions or if we may provide additional information.

Sincerely,

Laurie Kuiper
Senior Director, Government Relations
Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.