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Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
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July 9, 2024

Marie Grant
Commissioner
Maryland Insurance Administration
200 St. Paul Place
Baltimore, MD 21202

Submitted electronically via mary.kwei@maryland.gov.

RE: Kaiser Permanente Comments on Provider Directory Updates (HB 1292 of 2025)

Dear Commissioner Grant:

Thank you for holding an industry meeting on June 25 to solicit carrier feedback on the new provider directory requirements. Kaiser Permanente is the largest private integrated health care delivery system in the United States, delivering health care to over 12 million members in eight states and the District of Columbia.[1] Kaiser Permanente of the Mid-Atlantic States, which operates in Maryland, provides and coordinates complete health care services for over 825,000 members. In Maryland, we deliver care to approximately 475,000 members.

We offer the following general comments, and answers to the specific questions you posed are included in the appendix.

- **In General.** We note that state-specific requirements that aren't aligned with the No Surprises Act will add additional administrative burden without improvement to the member experience.

- **Standards for 2-day Timeframe.** If a provider sends information after business hours, we request that MIA consider the information received on the following business day.

- **Simple Versus Reviewable Requests.** Updates to phone numbers and websites are simple requests that can be updated easily within the 2-day timeframe. Reviewable requests, such as those that need contract amendments, a site visit, or credentialing, would require more than 2 days to ensure these steps are complete. We request that the MIA differentiate between these scenarios by regulation. The No Surprises Act leaves open the possibility for different standards based on complexity of the request.

[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

- **Future Effective Date.** KP may receive provider directory data element updates that are intended for a future effective date. Typically, when a facility is changing or adding a location, KP is notified well in advance. For updates with a future effective date, we recommend implementing the provider directory changes no earlier than the effective date, rather than within 2-working day of receiving the notification.

- **Site Visits.** When updates involve a new provider location for PCPs, OBGYNs and high-volume behavioral health providers, KP requires a site visit. Under the Maryland Medicaid HealthChoice agreement, plans must have evidence of an initial visit for each potential new PCP office. For facility address updates involving a new or added non-accredited location, KP will need to conduct a site visit in accordance with NCQA standards. Coordination for a site visit and the visit takes several days to weeks. To ensure accuracy and compliance with standards, we recommend that the 2-working day turnaround period for new provider locations and facility address updates to start after the site visit is successfully completed. The No Surprises Act leaves open this possibility.

- **Credentialing and Contract Amendments.** Federal law defines "provider directory information" to include certain information for "each health care provider or health care facility with which such plan or such issuer has a contractual relationship." Credentialing is a key part of the contracting process, and a contract or contract amendment cannot be signed until credentialing is complete. When a facility address is updated with a new or relocated location, KP must complete its credentialing process.

  Updates to provider primary location, health care facility name and facility address requires a contract amendment, which takes longer than two days. To maintain credentialing and contract standards, we recommend that the 2-working day turnaround period for these types of updates begin only after the contract amendments and credentialing have been finalized.

Thank you for the opportunity to comment. Please feel free to contact Allison Taylor at Allison.W.Taylor@kp.org or (919) 818-3285 with questions.

Sincerely,

Allison Taylor

Allison Taylor
Head of Government Relations
KP Mid-Atlantic Region
Kaiser Foundation Health Plan, Inc.

Appendix

1. The federal No Surprises Act has provisions regarding provider network directories. The Administration has authority to enforce the No Surprises Act. How should Maryland law be updated to be clearly consistent with the federal law, and prevent confusion as to the requirements? Is there consensus that the No Surprises Act requires a review of the entire provider network directory every ninety (90) days?

   We recommend that the MIA establish a clearly defined point for when the 2-day time frame begins. Section 15-112(t) of the Insurance Article requires a 2-working day update upon 'receipt of notification' for online provider directory update. Notification is presumed to have been received by the carrier 3 working days after the participating provider placed the notification in the U.S. mail or on the date recorded by the courier.

   The No Surprises Act requires verification every 90 days applies to all providers and online provider directory information within 2 business days of 'notice' when there are material changes. The No Surprises Act does not explicitly define 'notice.' In the absence of a statutory definition, we believe it is reasonable to allow time to verify updated information we receive from the provider.

2. Section 15-112(p)(3) requires carriers to "periodically review" their directories. If the Administration were to define this term through regulation, what is the appropriate frequency to require periodic reviews of provider directories, if not the 90 days specified in the No Surprises Act?

   We recommend that the to not adopt additional regulation; KP is currently reviewing all providers every 90 days. In addition to quarterly updates, KP refreshes data daily and conducts data quality checks.

3. Section 15-112(p)(3) of the Insurance Article also uses the term "reasonable sample size." If the Administration were to define this term by regulation, what is a reasonable sample size to expect to be used when conducting a review of a provider directory?

   We think that no definition is required because the No Surprises Act already requires quarterly reviews of all providers (i.e., not a sample).

4. What are the minimum required processes that should be undertaken as part of a provider directory review? For example: contact the provider's office, verify with the Board of Physicians, etc. What sources or processes are currently being used to collect and update provider information in directories?

   We think there should be a distinction between reviewing directory updates vs credentialing steps. KP conducts recredentialing every 2-days. Steps in the credentialing process would involve checking with Board of Physicians and OIG and confirming the provider has maintained their licensure.

Consistent with past advocacy, we recommend the statute be updated to require providers to provide us updates necessary for the provider directory.

5. Do carriers currently differentiate between a “meaningful error" and a “non-meaningful error" in a provider directory? For example, having directory information which lists the street address incorrectly versus listing the street address correctly, but the suite incorrectly. If not, is it reasonable to make the differentiation?

   KP differentiates based on the No Surprises Act’s specification on “material changes” for the 2-day update requirement.

6. Should carriers be required to report to the Commissioner network directory inaccuracies discovered during their review, date of discovery, and the date of correcting discovered inaccuracies?

   There is not a new requirement to report on inaccuracies in the statute, and we don’t recommend adding one. There is already a requirement to report on member reported inaccuracies from the provider directory and KP continues to meet this requirement. We would prefer not to have an additional administrative step that does not improve the member experience or improve the directories, including reporting.

   Furthermore, if the MIA pursues this, we would appreciate guidance on how to define an inaccuracy vs. a directory update. One could argue that all directory updates are made to address an inaccuracy. If the Commissioner would like to pursue additional reporting, we think it’s reasonable to make a report available upon request.

7. Should carriers be required to consider the number of received complaints related to inaccuracies in provider directories, and the result of those complaints in conducting their review of a provider directory?

   Since we review all provider records, per the No Surprises Act, this requirement would not add anything for Kaiser Permanente. There is already a requirement to report on member-reported inaccuracies from the provider directory and KP continues to meet this requirement.

8. In reviewing the information submitted to the Commissioner pursuant to § 15-112(p)(4), should the Administration conduct additional verification of the accuracy of the provider directory, and should there be a threshold that suggests noncompliance with the requirements of § 15-112(p)(3)?

   If the Administration chooses to conduct additional verifications and establish a threshold for non-compliance, we request that they publicize their methodology so that carriers can incorporate it into their processes for regular verifications and/or internal audits. Provider abrasion should be considered if their methodology is to conduct secret shopper calls since carriers are already reaching out to the providers regulatory for verification and audits.

There are already other federal requirements for secret shopper calls required for Medicaid and Medicare that could add to the Provider abrasion.

9. If a carrier is unable to reach a provider to verify their contact information, what steps are currently being taken to verify the provider's information is accurate? What additional steps, if any, are reasonable to expect to be taken? Should the provider information be presumed to be accurate, and remain in the provider directory, or presumed to be inaccurate and removed from the provider directory?

   Kaiser Permanente conducts direct emails, mail and/or phone calls. Once we determine that the provider is no longer available to the network, they are removed from the directories. If we don't hear from a provider, we assume the information in the directory is accurate.

10. What mechanisms are in place to address changes in practice locations, specialties, or acceptance of new patients?

    See response to question 9, above.

11. How are duplicate records for the same provider currently handled?

    If a provider practices at two locations, KP includes that provider in the directory twice. Otherwise, KP's directory does not contain duplicate records.

12. Should certain provider types, such as hospitals, be exempt from, or have different, periodic review requirements for provider directories? Please explain.

    They should not be exempt, but information for facilities does not change as often as professionals.

13. If an inaccuracy is discovered (through any method) and not corrected in a certain time period, what would be an appropriate penalty/range of penalties to impose?

    We have no comment on the penalty. Similar to earlier comments, depending on the situation and the time it takes to identify an inaccuracy, verify the correct information, and make that correction visible on the directory can vary depending on the situation. So whatever the penalty is, the MIA should consider those scenarios and/or clearly define the time frame expectations.

14. Are carriers currently collecting data regarding the frequency of out-of-network providers being treated as in-network due to the requirements under the No Surprises Act?

    As part of our Appeals process, members can file an Appeal to dispute that they are being charged inappropriately based on their benefit related to provider directories. For calendar year 2024, our data show that appeals and grievances were minimal.