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

July 14, 2016

Al Redmer, Jr.
Commissioner
Maryland Insurance Administration
200 St. Paul Pl., Ste. 2700
Baltimore, MD 21202

Submitted via email to: Lisa.Larson@maryland.gov

Re: Kaiser Permanente Comments on Topics for July 14, 2016 Public Hearing on Regulations to Implement HB 1318/SB 929

Dear Commissioner Redmer:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. ("Kaiser") appreciates the opportunity to provide comments regarding the Maryland Insurance Administration's (MIA) adoption of regulations to implement HB 1318/SB 929, concerning health insurance network access standards and provider network directories.

Kaiser provides coverage and delivers or arranges for the delivery of integrated health care services for over 660,000 members at more than 30 medical office buildings in Maryland, Virginia and the District of Columbia. Kaiser is a health maintenance organization ("HMO") comprised of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.; the Mid-Atlantic Permanente Medical Group, P.C., an independent medical group that is comprised of approximately 1,400 physicians in primary and specialty care who provide or arrange for the delivery of treatment to patients throughout the area; and Kaiser Foundation Hospitals, contracting with hospital providers that furnish inpatient and other hospital-based treatment to those members.

HB 1318/SB 929 directs the MIA to adopt regulations to establish quantitative and, if appropriate, non-quantitative criteria to evaluate the network sufficiency of health benefit plans offered by certain carriers that use provider panels. The law provides a list of items the MIA may take into consideration in adopting the regulations, including "geographic accessibility of primary care and specialty providers, including mental health and substance use disorder providers" (§15-112(D)(2)(I)) and "geographic variation and population dispersion" (§15-112(D)(2)(V), which are the focus of the July 14, 2016 public hearing.

As in our comment letter submitted for the June 2, 2016 hearing, we urge the MIA not to focus its regulations on the geographic location of carriers' network providers. While the Centers for Medicare & Medicaid Services (CMS) currently uses geographic access (travel time and distance) standards nearly exclusively in its measurement of provider accessibility in Medicare Advantage and the Federally Facilitated Marketplaces (FFMs), it does so primarily because

geographic access is simple and straightforward to measure—not because such measures assure appropriate access to care.

Geographic accessibility of providers should be considered, but should <u>not</u> be the primary focus in developing network adequacy regulations for Maryland.

We agree with the intent of HB 1318/SB 929 to ensure that consumers can access the health care providers and services they need when they need them. However, adopting maximum travel time and distance standards would do very little to achieve that goal. While they are easily quantifiable, geographic standards have the following significant flaws as a measure of health care access:

- they do not ensure that enrollees can actually receive the care they need at the time they need it;
- they do not take into account the quality of care or enrollee experience of care provided by a given clinician or facility;
- they do not take into account innovations in how health care is delivered;
- they work against integrated, coordinated care delivery by forcing carriers to maintain a highly geographically distributed provider network; and
- they do not take into account the geographic, topographic, population density and transportation differences across regions.

For these reasons, discussed in more detail below, the MIA's regulation of network adequacy should not focus on geographic accessibility. This is not to say that the provider office or facility location is not relevant; we agree that enrollees who wish to visit a provider in person should be able to reach the provider's office without unreasonable travel. However, there are many more meaningful measures of provider access, including quality outcomes, member satisfaction, timeliness and availability of appointments, access to care through remote options like telemedicine, and the convenience of co-located services provided through integrated delivery systems like Kaiser Permanente. We intend to provide further detail on these and other factors throughout the MIA's rulemaking process.

Geographic standards are not meaningful as measures of enrollees' actual access to care. Time and distance standards serve only to ensure that an in-network provider exists within a certain geographic distance of enrollees. They do not ensure that a practitioner has capacity to add the enrollee to his or her panel; that he or she is working at that location during the given week, day or time required for the enrollee; or that he or she has an available appointment within the timeframe needed by the enrollee depending on his or her clinical circumstances. Regulating provider networks based on the location of providers only ensures that an enrollee does not have to travel a long distance for care; it does not mean the enrollee will actually be able to receive care from the appropriate provider.

Geographic standards do not ensure a high quality or positive enrollee experience. Time and distance standards also do not ensure that the provider in close proximity is the right provider to meet the enrollee's clinical needs or care preferences; they do not ensure that the practitioner provides high quality care; and they do not take into account enrollees' satisfaction

with their experience of care from that provider. These are important elements of accessing care, and none of them are assured through a carrier's adherence to time and distance standards.

Further, the quality of specialty and subspecialty care is heavily influenced by the volume of services performed, which is a key reason for the establishment of centers of excellence or expertise. For example, low-volume, high-acuity subspecialties such as transplant, cardiac surgery, thoracic surgery and neurosurgery should be concentrated so they are performed more often by the same providers, leading to improved quality. If time and distance standards are in place, the ability to concentrate the volume of services is diminished by the need to have specialists distributed across a service area. This could affect quality of care and outcomes. If MIA intends to adopt time and distance standards, we strongly recommend that they not be adopted for subspecialties and that any standards for specialty care be lenient enough so as to not discourage the formation of higher volume centers of excellence.

Clinical practice is no longer dependent on office visits. Any network adequacy standards must recognize that clinical practice has extended beyond bricks-and-mortar locations. Increasingly, patients are choosing to access care remotely from their home or work via real-time telemedicine or telephone visits, through secure email to their primary care provider or specialist, or through remote monitoring of chronic conditions. This is also true for appointments with mental health and substance use disorder providers. These remote methods of accessing clinically appropriate care have been shown to be as effective and high quality as in-person care, and are often more convenient and preferred by patients. In recognition of this, many state Medicaid programs cover telehealth visits to the same extent as in-person visits, and an increasing number of states are mandating similar parity in their commercial markets.

In Maryland, HMOs, insurers and nonprofit health service plans (collectively, "carriers") are required to provide coverage for health care services appropriately delivered through telemedicine. Carriers are prohibited from excluding a health care service from coverage solely because it is delivered by telemedicine, and not through an in-person consultation or contact between a health care provider and a patient.[1] Moreover, carriers must reimburse a health care provider participating in the carrier's network for the diagnosis, consultation, and treatment of an insured patient for health care services covered under a health insurance contract or policy that can be appropriately provided through telemedicine. Further, the federal electronic health record ("EHR") meaningful use programs require provider investment in secure email, a patient portal, and population-based care tools that enable effective, convenient care and communication that is not face-to-face.

Given these shifts in policy and practice, care is increasingly being provided outside of traditional care settings – physician offices and hospitals – thereby diminishing the value of a provider's physical location as a measure of accessibility. It is critical that network adequacy standards adopted by the MIA take telemedicine, telephone visits and other care modalities into account.

[1] Md. Code Ann., Insurance, §15-139.

Stringent time and distance standards impede integrated care delivery. Time and distance standards effectively require that carriers contract with a highly geographically distributed provider network. Such contracting impedes the ability of integrated health care delivery systems like Kaiser to deliver the high quality, accessible, affordable care we currently provide to our members. Kaiser provides or arranges for the delivery of health care through its high-performing multispecialty medical group and a tightly connected system of full-service medical centers and hospitals, enabled by advanced medical technology and a robust EHR system. It is the integration of all these elements that enables effective, efficient delivery of care that produces high quality outcomes, achieves high levels of patient satisfaction, and optimizes use of providers' capacity.

We also co-locate our primary care providers and specialists in centers of excellence and expertise so that our members can see multiple providers, fill their prescriptions, and receive ancillary services such as lab and imaging in a single visit. This is contrasted with non-integrated systems in which several visits over several days or weeks may be needed to address a patient's needs. Additionally, through our integrated model, our providers can easily communicate in person and through our integrated EHR – facilitating consultation with colleagues and coordination of care. Requiring, through the imposition of time and distance standards, that integrated plans contract with a geographically dispersed set of providers would inhibit the quality, convenience and efficiency afforded by integrated systems.

There is significant variation in geography, topography, population density and transportation patterns within Maryland, which make impractical the application of time and distance standards. Applying a set of geographic access standards across Maryland would be difficult given the wide range of land and population features. For example, CMS' time and distance standards are applied at the county level. However, there is substantial internal diversity at the county level in terms of travel and transportation patterns, topographical features like mountains and bodies of water, and population density. For example, in northern Baltimore County areas such as Parkton and Freeland, the population density is far less than areas of the county such as Catonsville and Towson, and residents routinely travel longer distances during their daily schedules such as going to school, work, or the grocery store. Establishing the same standard across the county, as CMS does, ignores the internal diversity of a given county. Such standards similarly ignore differences in the land topography. For instance, CMS' standards are the same for Allegheny County as they are for Anne Arundel County, even though Allegheny County is in the western, more mountainous part of the state and Anne Arundel is largely flat with numerous tributaries and bridges. These land features are not factored into CMS' travel time and distance standards. Finally, time and distance standards do not take into account public transportation, which a significant portion of Maryland residents rely on. Depending on bus and metro routes, traveling even 2-3 miles could mean long travel times for individuals using public transportation.

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For the reasons discussed above, we urge the MIA not to focus its regulations on geographic accessibility. While it is important that a patient be able to visit a provider in person without unreasonable travel, there are many more meaningful measures of provider access.

Kaiser Permanente appreciates the MIA's consideration of these comments. 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 G. Kuiper
Senior Director, Government Relations
Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.