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

February 2, 2017

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

Submitted via email to: networkadequacy.mia@maryland.gov

Re: Kaiser Permanente Comments on Additional Network Adequacy Questions for February 2, 2017 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 670,000 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 1,300 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 our members.

In addition to the topics identified for each hearing, the MIA has posed several questions on its website. We are pleased to provide responses to these questions in preparation for the final hearing on February 2, 2017.

Question from July 13, 2016
Should Maryland follow the network adequacy standards required of carriers participating on the federal exchange? Why or why not?

As discussed in detail in our comment letters submitted for previous MIA network adequacy hearings, the Centers for Medicare & Medicaid Services (CMS) uses county-level geographic access (travel time and distance) standards nearly exclusively in its measurement of "reasonable access" in the Federally Facilitated Marketplaces (FFMs). Specifically, for plan years 2016, 2017 and 2018, CMS adopted a subset of the Medicare Advantage time and distance standards, focusing on the travel time and distance to 10 specialty/facility types, to determine whether a

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carrier is providing reasonable access. CMS provides a justification process allowing carriers to explain how they are otherwise providing reasonable access if they do not meet the time and distance standards.

We urge the MIA not to focus its network adequacy regulations on the geographic location of carriers' network providers or the members' travel time and distance to reach those locations. 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, adopting maximum travel time and distance standards would do very little to ensure *actual* access to care. While they are easily quantifiable, geographic standards have the following significant flaws as a measure of health care access:

- they *only* measure whether a particular type of contracted provider exists in a particular area;
- they do not ensure that enrollees can actually receive the care they need from their selected clinician 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, such as telemedicine and team-based care;
- 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 detail in our letters of June 2, 2016 and July 14, 2016, the MIA's regulation of network adequacy should not focus on geographic accessibility.

Question from August 1, 2016
Which specific standards or practices from California, Colorado and Washington will/will not benefit Maryland and why? Are there specific standards or practices from any other states that you believe will/will not benefit Maryland, and why?

Kaiser Permanente offers health plans in all three of the states listed by MIA.

<u>California</u>

The California Department of Managed Health Care (DMHC) uses a geographic access standard of 15 miles/30 minutes for primary care and acute care hospital services. DMHC provides for an "alternative standard" for geographic accessibility proposed by the carrier when those standards are unreasonably restrictive. DMHC regulations also include a set of "timely access" standards that measure the waiting times from the time at which the appointment is requested to when it is received. Timely access is defined as 48 or 96 hours for urgent care services (depending on whether pre-authorization is needed), 10 business days for primary care physician or non-physician mental health provider (e.g. counseling, substance abuse professionals), and 15 business days for specialist physician services or ancillary care (e.g. lab, imaging, physical therapy).

Kaiser appreciates that the DMHC standards do not focus exclusively on geographic access and that there is an option to provide an "alternative standard" when the geographic standard is unduly restrictive given our centralized/one-stop-shop model. However, the distance standard is reasonable in more densely populated areas but not in more rural areas. With respect to timely access, we believe the standards themselves are reasonable; however, it has been challenging for DMHC to measure compliance given health plans' different methods for determining wait times. Most plans must survey providers to determine appointment wait times, and plans were using different survey methods. On the other hand, within Kaiser's integrated delivery system, the large majority of appointments are scheduled and tracked through our centralized scheduling system, so most appointment wait time information can be tracked and audited. It is critical that, if the MIA decides to monitor appointment wait times, that the measurement is done fairly across all plans without imposing additional burden on integrated plans.

Colorado

In 2016, Colorado's Division of Insurance (DOI) adopted new network adequacy regulations, effective January 1, 2017. The regulations include appointment wait time standards, provider-to-enrollee ratio standards, time and distance standards, and essential community provider (ECP) standards. Colorado's prior standard was that of reasonable access, consistent with the previous National Association of Insurance Commissioners (NAIC) model language: "a network that is sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible without unreasonable delay." The DOI moved, over the course of a year, from the reasonable access standard to a very detailed and in some cases unduly strict set of standards. In particular, the DOI adopted the time and distance standards used for Medicare Advantage, which specify stringent driving times and distances for approximately 50 provider/facility types including 5 miles/10 minutes for primary care, and adopted provider-to-enrollee ratios of 1:1,000 for primary care, pediatrics, Ob/Gyn and mental/behavioral health.

We believe Colorado's geographic and provider-to-enrollee ratio standards are overly burdensome, and would be for Maryland's market as well. Even more important, however, such standards were not developed with integrated health care delivery systems like Kaiser Permanente in mind. As discussed in our comments of June 2, 2016 and July 14, 2016, stringent time and distance standards impede integrated care delivery by requiring that carriers contract with a highly geographically distributed provider network, which works against our highly organized and connected system of full-service medical centers. Additionally, as discussed in detail in our letter of September 1, 2016, provider-to-enrollee ratios function more like provider panel size in our integrated system due to the fact that our providers do not contract with other health plans. Therefore, a ratio of 1:1,000 would leave significant unused availability on provider panels, which is an inefficient use of valuable health care resources.

Washington

Washington's Office of the Insurance Commissioner (OIC) has regulations regarding provider ratios, appointment timeliness and geographic access. The standards vary depending on the type of care. For primary care, the ratio of primary care providers to enrollees within the service area

as a whole must meet or exceed the average ratio for the state for the prior plan year; 80 percent of enrollees within the service area must be within 30 miles of a sufficient number of primary care providers in urban areas and within 60 miles in rural areas (from either their residence or work); and enrollees must have access to a primary care appointment within 10 business days of requesting one. For specialists, the carrier must document the distribution of specialists in the network for the service area in relation to the population distribution within the service area; and enrollees must have access to an appointment with a specialist within 15 business days for non-urgent services. Urgent appointment wait times are the same as California's: 48 hours without prior authorization and 96 hours with prior authorization.

The OIC also has an "alternate access delivery system" request process available for networks that do not meet all the standards but provide access to medically necessary care on a reasonable basis without detriment to members' health and at no greater cost to the member. The carrier includes a justification for the alternate access delivery system request.

In general, we believe Washington's standards are reasonable and we support the availability of an "alternate access" request process to accommodate different models of care delivery. If Maryland adopts standards that are not workable for integrated delivery systems like Kaiser, we recommend the inclusion of a streamlined justification process to allow such systems to demonstrate network adequacy.

Question from November 7, 2016
The Maryland Insurance Administration has heard from several people that metrics based on numbers per population of members is not an effective way to measure access to care. What other ways might the MIA develop quantifiable criteria if metrics (such as x number of specialty providers per x number of members) are not used?

As we have discussed in our letter of September 1, 2016, provider-to-enrollee ratios do not provide insight into the actual accessibility or availability of care from an in-network provider. Rather, they require that a carrier have a certain number of contracted health care providers, regardless of whether the providers are accepting new patients, whether they have timely appointment availability, or whether they provide high quality care and a positive patient experience. We believe measures of actual access, such as quality/outcomes performance, member satisfaction, and appointment timeliness and availability (e.g. percent of providers accepting new patients), are more meaningful for health plan enrollees than the ratio of providers to members. It is important to note that provider-to-enrollee ratios are just one aspect of a multidimensional approach to provider access and are not a definitive measure of provider availability.

Importantly, provider-to-enrollee ratios used across the country today do not take into account different models of care delivery, such as the integrated and team-based care provided through a system like Kaiser's, and the fact that the majority of providers in our plan networks are exclusively available to Kaiser members. If the MIA pursues provider-to-enrollee ratios as a measure of network adequacy, it is critical that such ratios be differentiated to take into account integrated health plan models and care delivery models that optimize providers' scope of practice and health care resources.

Questions from November 28, 2016

If quantitative standards for provider-to-enrollee ratios by specialty are established, should the ratios account for (a) geographic region, and (b) the fact that certain specialists do not perform every service otherwise within the specialist's scope of practice? If so, how should a carrier be required to account for this?

Should a specialist only be counted if he or she performs the top five, ten, etc. procedures normally provided by providers in that specialty?

How should the carrier or MIA determine the most common procedures?

Is there a better way to quantify the number of specialists capable of furnishing health care services covered by the health insurance contract?

As discussed above and in our previous comment letters, Kaiser believes that provider-to-enrollee ratios hold little meaning as an access standard and that actual measures of access to providers are more meaningful and valuable for consumers and patients. If MIA adopts ratios, however, we do not believe they should be so granular as to specify ratios by geographic area or the fact that certain specialists do not perform every service within his or her scope of practice.

First, for many subspecialties, medicine is moving in the direction of consolidating high acuity/low volume procedures so that there are physicians who truly specialize in a small number of procedures in order to improve and maintain high quality and outcomes. The medical literature supports this shift in practice. As it is quite common that a specialist of a given type focuses a large portion of his or her practice on only a few procedures, to prevent such specialists from being counted in ratios would belie the true availability of care of that type.

Second, for many providers who do focus their practice, it does not mean that they are not able to do other procedures that are commonly performed by providers of that type. For example, primary care providers are generally expected to handle chronic conditions, but a given PCP may wish to spend much of his or her time focusing on patients with depression.

Third, it would be very difficult to determine and maintain the "top 5" or "top 10" procedures "normally" provided by a given specialty in order to determine a standard. It would not seem appropriate for MIA to determine which procedures/interventions are the most common in a medical specialty; that would probably be more appropriate for the medical specialty society to undertake, if it is done at all.

Finally, developing the actual standards for counting providers based on which services they do and do not provide would be very challenging. Would MIA assign a fraction of a provider based on the volume of certain services a particular provider typically performs? How would MIA monitor what services are typically performed?

Rather than prescribing rules regarding how many of which services must be provided by a particular type of provider in order to count for network adequacy, we recommend that MIA focus on measures of actual access, as we have discussed, and on reported access complaints, which would indicate if members are having trouble receiving the specific care they need.

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In closing, Kaiser Permanente believes network adequacy is a very important area of regulation and that Maryland has the opportunity to be a leader among states in the development of reasonable network adequacy rules that ensure appropriate access for patients and consumers while ensuring that carriers can continue to offer affordable products. We appreciate the thoughtfulness and transparency with which the MIA has conducted this process. We request that the MIA continue the process by releasing a working draft for stakeholder feedback prior to the formal proposal of regulations.

Kaiser 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.