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

May 8, 2017

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

Re: Draft Title 31 MARYLAND INSURANCE ADMINISTRATION, Subtitle 10 HEALTH INSURANCE – GENERAL, *Chapter 44 Network Adequacy*

Dear Commissioner Redmer:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. ("Kaiser") appreciates the opportunity to provide comments on draft *Chapter 44 Network Adequacy* of Subtitle 10 HEALTH INSURANCE – GENERAL which the MIA distributed on April 10, 2017.

Kaiser Permanente believes it is important that health plan enrollees have timely access to high-quality, affordable health care. We appreciate that the MIA has considered the important differences in how integrated delivery systems provide access to care and has included in the draft regulation alternatives that aim to ensure that Kaiser can continue to provide high-quality care and coverage to residents of Maryland. However, we believe there are sections of the draft regulations that should be amended or clarified to ensure appropriate applicability to Kaiser's care delivery model. We also urge MIA to reconsider its adoption of the Centers for Medicare & Medicaid Services (CMS) distance standards, which we believe are not well tailored to Maryland's commercial market or to the effectuation of the authorizing statute, Insurance Article §15-112.

We appreciate your consideration of the following recommended amendments and revisions to draft *Chapter 44 Network Adequacy:*

.02 Definitions

1. Amend Section .02 (25) as follows:

(25) ~~"Staff Model HMO" means a type of health maintenance organization that employs its own physicians and health care practitioners on a salaried basis in health maintenance organization buildings to provide care to enrollees of the health maintenance organization.~~ "Group Model HMO" means a type of health maintenance organization that:
(a) contracts with one multispecialty group of physicians who are employed by and shareholders of the multispecialty group; and
(b) provides and/or arranges for the provision of physician and other health care services to patients at medical facilities operated by the HMO.

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Rationale: Based on our review of the MIA's draft regulations and our understanding of the health insurance market in Maryland, the definition of the term "staff model HMO" is intended to describe Kaiser Permanente. Since Kaiser is not a staff model HMO and since we are not aware of staff model HMOs operating in Maryland, we request that this language be stricken from the draft regulation and replaced with language that is similar to the definition of "group model health maintenance organization" contained in Md. Code Ann., Health General, §19-713.6. We have revised this language slightly by including non-physician services in subparagraph (b) to ensure that it is applicable to *Chapter 44 Network Adequacy*.

2. Incorporate Telemedicine into Standards

The draft regulations include a definition of "telemedicine" but do not include such term in the network adequacy standards. Given the increasing use of real-time video visits and other telehealth modalities in care delivery, we believe it is important that access requirements keep pace by considering such modalities as equal to in-person care (where clinically appropriate).

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. 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. Telemedicine options often make communication between patient and provider more efficient, so care decisions can be made sooner, thereby improving quality outcomes. Further, many telemedicine/telehealth options can fully address the member's clinical needs, making additional or follow-up care unnecessary and the overall care experience more convenient and efficient. Recognizing the advantages of remote care options, Maryland has mandated coverage of health care services appropriately delivered through telemedicine to the same extent as in-person visits.

We ask that MIA consider adding provisions to the final regulations that would:

- Consider telemedicine visits that are clinically appropriate (in accordance with Maryland clinical practice requirements), elected by the enrollee, and performed by a participating provider to be included toward meeting the requirements of section *.05 Waiting Times for Appointments with Providers*.
- Permit carriers that offer integrated telemedicine visits – telemedicine visits that are provided by a participating provider and integrated with the provider's or the carrier's electronic health record system – to meet a less rigorous set of geographic accessibility standards under section *.04 Geographic Accessibility of Providers*, such as a greater maximum distance (e.g. 20 percent higher) or a lower percentage of enrollees within the maximum distance (the distance standard applies to, e.g., 80 percent of enrollees).

These steps would facilitate appropriate use of telemedicine in the Maryland commercial market while improving the efficiency of care delivery for enrollees who elect to use them.

.04 Geographic Accessibility of Providers

1. Adopt Standards Better Tailored to Maryland's Commercial Market

Kaiser appreciates that the MIA has provided an adjusted set of distance standards for group model HMOs, recognizing the important differences in how high-quality care is delivered through our integrated system. As a general matter, however, we remain concerned that MIA's draft regulations effectively require providers' physical location to be the primary determining factor as to whether they are included in health plan networks—as opposed to more important factors affecting access to high-quality care such as providers' quality performance, patient satisfaction and cultural competence. While we agree that enrollees should not have to travel unreasonable distances to receive care, we are particularly concerned about the MIA's adoption of CMS' stringent distance standards as the baseline. The CMS standards are overly burdensome in comparison with the intent of the statute and do not reflect the realities of accessing care in Maryland's commercial market today.

As we commented throughout the development of the draft regulations, distance standards are not a meaningful measure of actual access to care—they do nothing to ensure that enrollees can actually receive the right care at the time they need it. Application of CMS' strict distance standards assume (1) that enrollees' priority in selecting a provider is the provider's proximity to their home or work, rather than important criteria such as quality performance, patient satisfaction, cultural competence, and referral by another provider; (2) that enrollees drive instead of using public transit; and (3) that counties are internally uniform in population density. Strict distance standards also work against integrated care delivery by requiring that providers and services be distributed across the service area rather than allowing them to be concentrated in multispecialty centers, such as Kaiser's medical centers. Our members, in most cases, can visit one of our medical centers and have the convenience of receiving all or most of their needed care in a single round-trip on the same day instead of at multiple locations over multiple days or weeks.

We appreciate that the MIA recognizes any distance standards should be adjusted for group model HMOs like Kaiser given the high-quality, integrated, one-stop-shop care experience we provide. However, the CMS distance standards are overly burdensome for the Maryland commercial market as a whole—going well beyond effectuating the intent of the statute, which requires access "without unreasonable travel"[1]—and an adjustment to CMS' standards for group model HMOs remains unworkable in many cases. The statute does not mandate strict distance standards or that MIA define a standard for every type of service. For all carriers, adhering to the MIA's extensive list of distance standards (more extensive than CMS' list of provider and facility types) and applying the standards to 100 percent of enrollees (whereas CMS' standards are applied to 90 percent of Medicare beneficiaries) imposes a huge administrative burden on carriers as well as potentially higher product costs for enrollees due to the need to include more contracted providers in the network. Furthermore, MIA's adoption of appointment wait time standards and provider-to-enrollee ratios reduce the need for strict distance standards.

[1] *See* Insurance Article, §15-112(b)(3)(I), Annotated Code of Maryland.

In addition to being overly burdensome in comparison to the intent of the statute, the CMS standards are based on definitions of counties and cities that are not workable in many of Maryland's counties. Within Maryland's counties, there is substantial internal diversity 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 for everyday practices such as going to school, work, or the grocery store. Other Maryland counties, like Calvert and Carroll, are much more like Rural or Micro counties than Metro counties. Establishing the same standard across full counties of a given population ignores the internal diversity of any individual county.

We recommend that the MIA adopt distance standards that are more workable for the Maryland commercial market and that ensure travel is not unreasonable without being unduly burdensome, as the CMS standards are. Maryland could adopt a simple set of distance standards to begin with, such as a standard for primary care and a standard for specialty care. In Large Metro areas, for example, the distance standard could be 10 miles for primary care and 15 miles for specialty care. Those standards would then be adjusted for group model HMOs (e.g. 20 miles for primary care and 30 miles for specialty care). MIA could then monitor performance and enrollee complaints to determine if enrollees are having to travel unreasonable distances and more stringent standards are needed. Alternatively, the MIA could adopt a lower enrollee percentage such as the 90 percent that CMS uses. These approaches would effectuate the intent of the statute without imposing heavy administrative burdens on carriers, increasing the cost of coverage, and disrupting integrated care delivery systems' ability to provide high-quality integrated care to residents of Maryland.

2. Amend Section .04(B) as follows:

B. ~~Staff~~ Group Model HMO Plans.
(1) Each ~~Staff~~ Group Model HMO plan's provider panel shall have sufficient primary care physicians, specialty providers, mental health and substance use disorder providers, hospitals, and health care facilities to accept each enrollee within the maximum travel distance standards listed in the chart in § B(2) of this regulation for each type of specialty and geographic area. The distances stated in § B(2) shall be measured from the enrollee's location, home or place of employment, from which the enrollee gains eligibility for participation in the ~~staff~~ group model HMO plan.

> **Rationale:** These textual changes are intended to conform with the change to the definition from "staff model HMO" to "group model HMO".

3. Adjust Distances for Group Model HMO Plans

Should MIA proceed with its proposal to use the CMS standards as the basis for geographic accessibility, we believe there are a number of instances where the mileage stated in the chart under .04(B)(2) needs to be adjusted to account for our integrated model. For example, "Gynecology only" has not been adjusted at all from the standards under .04(A). Additionally, many of the standards for services in Metro counties have not been adjusted from the standards

under .04(A), including Allery/Immunology, Dermatology, Endocrinology, Licensed Clinical Social Worker, Orthopedic Surgery and others.

We would appreciate the opportunity to discuss further with you the approach to determining the distance standards for group model HMOs and to request that you consider changes to ensure that Kaiser can continue to serve residents of Maryland through our successful integrated care delivery system. Although in some cases the travel distance for a single visit is slightly further, enrollees visiting our full service multispecialty centers have the convenience of access to virtually all needed care under one roof in a single trip. This is in contrast to network model plans where enrollees typically need to visit multiple locations for a given episode of care.

A case study for two patients, Joseph Jones and William Wilson[2], demonstrates the convenience of our integrated care delivery model. Joseph and William both live in Ellicott City, Maryland. Each patient has an annual preventive exam with a PCP and wishes to discuss some questions regarding some gastrointestinal symptoms.

Kaiser Permanente	**Non-Integrated Health Plan**
• Joseph drives to the Kaiser South Baltimore Medical Center, which is 10 miles and 22 minutes from his home. At the South Baltimore Center, he meets with his PCP. He shares his symptom information with his PCP, and then has an on-call GI join as a consult and deliver recommendations for care and a prescription. All of this is documented in his electronic health record (EHR) in KP HealthConnect®. • Before Joseph leaves the South Baltimore center, he is able to pick his prescription up from the pharmacy downstairs. • Joseph drives home, and is able to start treatment via medication immediately. • After a few days of treatment, Joseph has questions about his prescription. He emails his doctor and gets a response back within 24 hours. **Total Round-Trip Travel Distance: 20 miles** **Total Round-Trip Travel Time: 44 minutes** **Encounters: 1, PCP, Specialist, and Pharmacy in single trip**	• William goes to see a nearby PCP, who is 3 miles and 10 minutes from his apartment. The PCP tells him he should see a GI physician. William goes home and makes the first appointment with a GI he can find for the next week. The PCP documents this and other notes about William on her office's EHR. • The next week, William goes to the GI's office, located in a different office than the PCP, but only 6 miles and 15 minutes away. The GI documents this on his office's EHR, which is not connected to the PCP's EHR. • The visit goes well, and the GI prescribes William medication to help with his condition, which he phones in to the pharmacy that is 1 mile from William's house, which William picks up later that day. • After a few days of treatment, William has some questions about his prescription, and calls his GI's office and leaves a message; his GI calls back within 2 business days. **Total Round-Trip Travel Distance: 20 miles** **Total Round-Trip Travel Time: 50 minutes** **Encounters: 2 physician visits one week apart;**

[2] "Joseph Jones" is a pseudonym for a Kaiser member. William Wilson is a hypothetical member of a non-integrated health plan. This example is based on sample Kaiser member-level data and other time/distance location from other carriers pulled from www.zocdoc.com and mapping from www.google.com.

Duration of Care Episode: 6 days	**separate trip to pharmacy** **Duration of Care Episode: 14 days**

4. Amend Section .04(C) as follows:

C. Each plan <u>that is not a group model HMO plan</u> shall have 30 percent of the available essential community providers as part of its provider panel in each of the defined rating areas.

Rationale: Kaiser Permanente requests that Section .04(C) be amended to exempt integrated delivery systems from the essential community provider (ECP) requirement. Alternatively, Kaiser requests that the MIA include an alternative standard, in accordance with the authorizing statute.[3]

All members of Kaiser Permanente, regardless of income or plan, have equal access to our full network of high-quality Permanente providers and Kaiser facilities. We do not create smaller or different networks for members of lower cost plans, as other carriers may. It is for this reason that the ECP requirement was needed in the Affordable Care Act.

Much of the value of an integrated delivery system comes from having highly integrated information systems, clinical protocols, and thorough monitoring and managing of all patient information. Requiring Kaiser Permanente to contract with non-Kaiser providers to meet the MIA's proposed 30 percent ECP standard would fundamentally change how we provide care to our members and would undermine the ability of our integrated care teams to provide high levels of consistent, quality care. Therefore, we request that MIA exempt group model HMOs from the ECP requirement.[4]

Alternative: If the MIA does not exempt group model HMOs from the ECP standard, Kaiser requests that the language in subsection (C) of the draft regulations be amended to include the "Alternative ECP Network Inclusion Standards" that are contained in the Maryland Health Benefit Exchange's *2018 Letter to Issuers Seeking to Participate in Maryland Health Connection.* Our proposed amendment below adds the MHBE language for group model HMO plans to subsection (C):

C. ~~Each plan shall have 30 percent of the available essential community providers as part of its provider panel in each of the defined rating areas.~~ <u>Essential Community Providers:</u>

[3] *See* Insurance Article, §15-112(b)(3)(II)(2), Annotated Code of Maryland: "For a carrier that provides a majority of covered professional services through physicians employed by a single contracted medical group and through health care providers employed by the carrier, include alternative standards for addressing the needs of low-income, medically underserved individuals."

[4] We also note that draft network adequacy regulations distributed April 5, 2017 by the Department of Insurance, Securities and Banking in the District of Columbia provide an exemption from ECP standards for integrated delivery systems such as Kaiser Permanente.

(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.
(2) Each group model HMO plan shall demonstrate through a narrative that low income members receive appropriate access to care and satisfactory service. The group model HMO must submit to the MIA:
(a) Provider quality and patient satisfaction metrics including National Quality Forum metrics (either endorsed or submitted for endorsement by NQF),
(b) The results of a statistically rigorous CAHPS survey of cost-sharing reduction eligible members,
(c) A narrative explanation that describes the extent to which the HMO's provider sites are accessible to, and have services that meet the needs of specific underserved populations including:
i. Individuals with HIV/AIDS (including those with comorbid behavioral health conditions);
ii. American Indians and Alaska Natives (AI/AN);
iii. Low-income and underserved individuals seeking women's health and reproductive health services; and
iv. Other specific populations served by ECPs in the service area.

.05 Waiting Times for Appointments with Providers.

Amend Section .05(C) as follows:

C. Appointment Wait Time Standards

Wait Time Standards	
Urgent Care (including medical, mental health, and substance use disorder)	*48 hours (If prior authorization required)* *96 hours (If prior authorization is not required)*
Routine Primary Care	*15 calendar days*
Preventive Visit/Well Visit	*30 calendar days*
Non-Urgent Specialty Care	*30 calendar days*
Non-Urgent Ancillary Services	*30 calendar days*
Non-Urgent Mental Health/Substance Use Disorder provider	*~~10~~ 15 calendar days*

Rationale: Section .05(C) includes an appointment wait time standard of 10 calendar days for non-urgent mental health/substance use disorder services. Kaiser Permanente requests that the wait time standard for these services be increased to 15 calendar days to align with the standard for primary care. Given the limited supply of mental health/substance use disorder providers in Maryland, it would be difficult for carriers to ensure that members can receive mental health/substance use disorder services within 10 calendar days. Furthermore, it is unclear why non-urgent mental health/substance use disorder services should have a shorter wait time standard than primary care or any other

type of care. If a member needs urgent or emergency mental health services, the timeframes for urgent or emergency care would apply.

.07 Waiver Request Requirements.

Amend Section .07(B) as follows:

A. A carrier may apply for a network adequacy waiver, for up to one year, of one or more of the network adequacy requirements in this Chapter.
B.(1) For carriers that are not group model HMOs, ~~T~~the Commissioner may find good cause to grant the network adequacy waiver request if the carrier demonstrates that providers or physicians necessary for an adequate local market network are:

(~~1~~a) Not available to contract;
(~~2~~b) Not available in sufficient numbers;
(~~3~~c) Available, but have refused to contract with the carrier on any terms or on terms that are reasonable; or
(4d) Unable to reach agreement with the carrier.

(2) For carriers that are group model HMOs, the Commissioner may find good cause to grant the network adequacy waiver request if the carrier demonstrates how it ensures adequacy, accessibility, transparency and quality of health care services through its integrated delivery model.

Rationale: The language in Subsection .07 allows carriers to apply for a waiver from one or more of the network adequacy requirements in *Chapter 44*. While Kaiser Permanente supports and appreciates the inclusion of the waiver language, the circumstances under which the Commissioner may find cause to grant a waiver applies only to carriers whose networks are comprised of contracted providers. As currently written, this subsection does not seem to allow group model HMOs to seek a waiver. Kaiser Permanente requests that the language in Subsection .07 be amended as shown above so it is applicable to all carriers including group model HMOs.

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In closing, Kaiser Permanente believes network adequacy is a very important area of regulation and that Maryland should take the lead among states in the development of meaningful network adequacy rules that ensure appropriate access for patients and consumers while ensuring that carriers can continue to offer affordable products.

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.