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

August 21, 2017

Lisa Larson
Regulations Manager
Maryland Insurance Administration
200 St. Paul Place
Suite 2700
Baltimore, MD 21202

Re: Proposed Regulations *COMAR 31.10.44 Network Adequacy*

Dear Ms Larson:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. ("Kaiser Permanente") appreciates the opportunity to provide comments on proposed *COMAR 31.10.44 Network Adequacy* which was published in the July 21, 2017 issue of the Maryland Register. Kaiser Permanente believes it is important that health plan enrollees have timely access to high-quality, affordable health care. We appreciate that the Insurance Administration has considered the important differences in how group model HMOs provide access to care and included alternatives in the proposed regulations that aim to ensure that Kaiser Permanente can continue to provide high-quality care and coverage to Maryland residents. However, we believe that there are sections of the proposed regulations that should be amended or clarified to ensure appropriate applicability to Kaiser Permanente's care delivery model.

Kaiser Permanente requests the following clarifications and amendments to the proposed regulations:

.02 Definitions.

The definitions in Section .02(B)(19), (21) and (24) are as follows:

> **(19) "Rural area" means a region that, according to the Maryland Department of Planning, has a human population of less than 1,000 per square mile.**
>
> **(21) "Suburban area" means a region that, according to the Maryland Department of Planning, has a human population equal to or more than 1,000 per square mile, but less than 3,000 per square mile.**
>
> **(24) "Urban area" means a region that, according to the Maryland Department of Planning, has a human population equal to or greater than 3,000 per square mile,**

COMMENT: Kaiser Permanente appreciates the Insurance Administration's review of its previously proposed approach to categorizing geographic areas within Maryland. We commented previously that the categories used by the federal Centers for Medicare & Medicaid Services (i.e. Large Metro, Metro, Micro, Rural, CEAC) were not appropriately tailored for

Maryland. However, it is unclear from the proposed regulations what is meant by the term "region" or which areas within Maryland would be categorized as rural, suburban or urban. As a result, our comments related to Section .04(B)(4) below are limited and incomplete. With the shift to definitions based on reasonable density categories, we believe categorizing at the county level may be more workable than the Insurance Administration's prior proposal and more administratively workable for both the Insurance Administration and carriers.

.04 Travel Distance Standards.

Kaiser Permanente appreciates that the Insurance Administration has provided an adjusted set of travel distance standards for group model HMOs given the high-quality, integrated, one-stop-shop care experience we provide. As we have observed in previous comments, strict distance standards 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 multi-specialty centers, such as Kaiser Permanente'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, including primary care, specialty care and ancillary services like radiology and lab work, in a single round-trip on the same day instead of at multiple locations over multiple days or weeks. In reviewing the table under proposed Section .04(B), we appreciate that the Insurance Administration has made some adjustments to the distance standards, but we believe that additional adjustments are needed to reflect the differences in our care delivery model.

Kaiser Permanente requests the following clarifications and amendments to Section .04(B)(1), (2) and (4):

(1) Amend Section .04(B)(1) as follows to include an adjustment to the travel distance standards for telehealth utilization:

> **B. Group Model HMO Plans Sufficiency Standards.**
>
> **(1) Each group model HMO's health benefit plan's provider panel shall have within the geographic area served by the group model HMO's network or networks, sufficient primary care physicians, specialty providers, mental health and substance use disorder providers, hospitals, and health care facilities to meet the maximum travel distance standards listed in the chart in §B(4) of this regulation for each type of geographic area. *For group model HMOs that provide a substantial proportion of care through integrated telehealth visits, the group model HMO shall meet the maximum travel distance standards for at least 80% of the group model HMO's enrollees*. The distances listed in §B(4) of this regulation shall be measured from the enrollee's place of residence or place of employment from which the enrollee gains eligibility for participation in the group model HMO's health benefit plan.**

COMMENT: The proposed regulations include a definition of "telehealth" and allow carriers to consider telehealth utilization toward meeting the appointment waiting time standards. The proposed regulations do not, however, consider the value of telehealth toward reducing the need for travel when telehealth is clinically appropriate for the member's condition.

Increasingly, patients are choosing to access care remotely from their home or work via real-time telehealth or telephone visits, through secure e-mail 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. Telehealth options often make communication between patient and provider more efficient so care decisions can be made sooner, which improves quality outcomes. Further, many 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 telehealth to the same extent as in-person visits.

Within our integrated system, members are increasingly choosing to receive care through telehealth: today, nearly half of office visits for our members are done through telehealth and members are very satisfied with the care they receive through these modalities.

With this experience in mind, Kaiser Permanente believes telehealth should be factored into considerations of geographic access to care. We request that the Insurance Administration amend Section .04(B)(1) so the distance standards that apply to group model HMOs that offer integrated telehealth visits – telehealth visits that are provided by a participating provider and integrated with the provider's or the carrier's electronic health record system – apply to 80% of its enrollees. We believe this is a reasonable adjustment given the significant portion of visits that members are choosing to do via telehealth.

(2) Clarify Section .04(B)(2) which states the following:

B. Group Model HMO Plans Sufficiency Standards.

(2) When an enrollee elects to utilize a gynecologist, pediatrician, or certified registered nurse practitioner for primary care, a carrier may consider that utilization as a part of its meeting the standards listed in §B(4) of this regulation.

COMMENT: It is unclear under which specific distance standard(s) in Section .04(B)(4) a group model HMO may consider the utilization of a gynecologist, pediatrician, or certified registered nurse practitioner. We request that the Insurance Administration clarify whether such utilization should be considered under the standard for primary care, the standards for gynecologists and pediatricians, or both.

(3) Clarify the providers and facilities in Section .04(B)(4).

COMMENT: Kaiser Permanente requests clarification on several terms that are included here:

1. Under Provider Type, we request that the Insurance Administration provide a definition for "Other Provider Not Listed" as it is unclear which types of providers would need to be measured under this standard or how carriers would report them. Alternatively, we request that this provider type be removed from the standards.
2. Similarly, under Facility Type, we request that the Insurance Administration provide a definition for "Other Facilities" or remove this type from the standards.
3. Under Facility Type, "Applied Behavioral Analysis" is included. We are not aware of Applied Behavioral Analysis facilities and recommend that this service type be removed from the standards.

(4) Amend Section .04(B)(4) to remove the "Gynecology Only" distance standards under Provider Type.

COMMENT: As we have discussed with the Insurance Administration, in Kaiser Permanente's integrated model in the Mid-Atlantic region, we do not typically utilize OB/GYN physicians as "gynecology only" providers. We consider OB/GYN physicians as primary care providers and they partner with members' primary care providers to track preventive care measures. We do not subspecialize our OB/GYN physicians to provider only gynecology or only obstetric services. In the clinic, all of our OB/GYNs have panels of women for whom they can provide both obstetrical and gynecologic services; therefore, the standard for gynecology only does not apply to our practice within Kaiser Permanente. Given the benefits of this organization of care, there is not a need for a "Gynecology only" standard and we request that that standard be removed from the chart in .04(B)(4).

(5) Clarify definitions in Section .02 and amend the distance standards in Section .04(B)(4).

COMMENT As discussed in our comment above related to Section .02, without more specific information about what is considered a "region" for purposes of categorizing regions into urban, suburban and rural, Kaiser Permanente is unable to model our performance on the proposed maximum distance standards for group model HMOs. However, based on a comparison of the standards proposed for group model HMOs under .04(B)(4) to those proposed for non-group model HMOs under .04(A)(4), we believe adjustments to some of the standards may be needed to account for our integrated model of care delivery.

We appreciate that the Insurance Administration has provided an adjusted set of travel distance standards for group model HMOs, recognizing the important differences in how health care is delivered through our integrated system. A number of the distance standards in the chart under Section .04(B)(4) that apply to group model HMOs are identical to the distance standards in Section .04(A)(4) for non-group model HMOs and should be similarly adjusted to account for our integrated model. We have reproduced the chart below and have noted our requested amendments in red, reflecting adjustments to particular standards as well

as our comments above regarding the "Gynecology only" provider type and "Applied Behavioral Analysis" facility type.

B. Group Model HMO Plans Sufficiency Standards
(4) Chart of Travel Distance Standards

	Urban Area Maximum Distance (miles)	Suburban Area Maximum Distance	Rural Area Maximum Distance (miles)
Provider Type:			
Primary Care Physician	15	20	~~45~~ 60
Gynecology, OB/GYN	15	20	~~45~~ 60
Pediatrics—Routine/Primary Care	15	20	~~45~~ 60
Allergy and Immunology	20	~~30~~ 40	75
Cardiovascular Disease	15	25	60
Chiropractic	20	~~30~~ 40	75
Dermatology	20	~~30~~ 40	60
Endocrinology	20	~~40~~ 50	90
ENT/Otolaryngology	20	~~30~~ 40	75
Gastroenterology	20	~~30~~ 40	60
General Surgery	20	30	60
~~Gynecology Only~~	~~15~~	~~30~~	~~60~~
Licensed Clinical Social Worker	15	30	75
Nephrology	~~15~~ 20	30	75
Neurology	15	~~30~~ 40	60
Oncology—Medical, Surgical	15	30	60
Oncology—Radiation/Radiation Oncology	~~15~~ 20	~~40~~ 50	90
Ophthalmology	15	~~20~~ 25	60
Physiatry, Rehabilitative Medicine	~~15~~ 20	~~30~~ 40	75
Plastic Surgery	~~15~~ 20	~~40~~ 50	90
Podiatry	15	~~30~~ 40	90
Psychiatry	15	30	60
Psychology	15	30	~~60~~ 75
Pulmonology	15	~~30~~ 40	60
Rheumatology	~~15~~ 20	~~40~~ 50	90
Urology	15	~~30~~ 40	60
[Other Provider Not Listed]	20	~~40~~ 50	90
Facility Type:			
Pharmacy	~~5~~ 15	~~10~~ 20	~~30~~ 60
Acute Inpatient Hospitals	15	~~30~~ 40	60
~~Applied Behavioral Analysis~~	~~15~~	~~30~~	~~60~~
Critical Care Services— Intensive Care Units	15	~~30~~ 40	120
Diagnostic Radiology	15	~~30~~ 40	60
Inpatient Psychiatric Facility	~~15~~ 20	~~45~~ 60	75
Outpatient Dialysis	15	~~30~~ 40	60
Outpatient Infusion/Chemotherapy	15	~~30~~ 40	60
Skilled Nursing Facilities	15	~~30~~ 40	60
Surgical Services (Outpatient or Ambulatory Surgical Center)	~~10~~ 15	~~30~~ 40	60
[Other Facilities]	~~15~~ 20	~~40~~ 50	120

Section .04(C) related to Essential Community Providers

Kaiser Permanente requests that the language in Section .04(C) of the proposed regulations be amended as follows 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* for group model HMOs:

> **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.~~ *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.**
> ***(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.***

COMMENT: Section .04(C) in the proposed regulations require that each provider panel of a carrier include at least 30 percent of the available essential community providers (ECP) in each of the urban, rural, and suburban areas. In Kaiser Permanente's comment letter dated May 8, 2017, we requested that this language be amended for group model HMOs. Maryland state law requires an alternate ECP standard for HMOs that are group model plans. Maryland Insurance Article, §15-112(b)(3) states the following:

> **(3) For a carrier that is an insurer, a nonprofit health service plan, or a health maintenance organization, the standards required under paragraph (1)(i) of this subsection shall:**
> > **(i) ensure that all enrollees, including adults and children, have access to providers and covered services without unreasonable travel or delay; and (ii) 1. include standards that ensure access to providers, including essential community providers, that serve predominantly low-income and medically underserved individuals; or**

2. 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.

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 Insurance Administration's proposed 30% 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 to comply with state law, the Insurance Administration include an alternate ECP standard in Section .04(C) for group model HMOs. The amendment proposed above, which is identical to 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,* is the best approach to meet the alternative ECP requirement that is mandated in state law.

.05 Appointment Waiting Time Standards.

Kaiser Permanente requests the following clarifications and amendments to Section .05:

(1) Amend Section .05(A) as follows:

A. Sufficiency Standards.

(1) Subject to §B of this regulation, each carrier's provider panel shall meet the waiting time standards listed in §C of this regulation for at least ~~95~~ *80* percent of the enrollees covered under health benefit plans that use that provider panel.

COMMENT: Kaiser Permanente supports appointment waiting time standards as a measure of true network access. However, we believe that the 95% threshold included in the proposed regulations is too burdensome for carriers to meet and we request that the threshold be amended to 80%.

We also note that Kaiser Permanente as an integrated model has the ability to review data on most appointment wait times while most network model plans would likely need to survey providers in order to know whether wait time standards are being met (similar to how the State of California has implemented its timely access regulations). It is important that the MIA recognize this distinction and not hold different carriers to different standards based on differences in data collection/measurement methodologies.

It is also important to understand which types of appointments are subject to measurement and reporting. For instance, some appointments are initial consultations and others are

follow-up appointments or ongoing regular treatment. We believe that measurement of waiting times should apply to initial consultations, and not to follow-up appointments.

We would like to work with the Insurance Administration to share our experience and ensure fair implementation of these regulations.

(2) Amend Section .05(B) and provide clarification as follows:

> **B. Preventive care services and periodic follow-up care, including but not limited to, standing referrals to specialty providers for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating provider acting within the scope of the provider's license, certification, or other authorization. *Health plans may exclude advance appointments for preventive and follow-up care made at least 30 days in advance from the measurement of the appointment waiting time standards.***

COMMENT: Section .05(B) correctly gives deference to preventive and follow-up care appointments that are made in advance but does not provide clarity as to how these appointments should be considered when measuring health plan compliance with the appointment waiting time standards. Kaiser Permanente requests that the language in Section .05(B) be amended to allow health plans to exclude appointments for preventive and follow-up care that are scheduled 30 days or more in advance from the measurement of these standards.

Our integrated health care delivery model is focused on prevention and wellness. Our physicians and providers actively encourage and advise their patients to seek preventive and follow-up care, whenever appropriate. As such, Kaiser Permanente members often make appointments for this type of care well in advance to coordinate with their employment schedules and the schedules of their family members. Up to 15% of appointments are requested for dates well in advance rather than the first-available appointment. We request that the Insurance Administration state clearly in the regulations that such advance scheduling is excluded from the wait time standards.

(3) Amend Section .05(C) and provide clarification as follows:

C. Chart of Waiting Time Standards

Wait Time Standards	
Urgent Care (including medical, mental health, and substance use disorder services)	**72 hours**
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	**~~10~~ *15* calendar days**

Disorder provider	

COMMENT: Section .05(C) includes an appointment waiting 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 all 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 time frames for urgent or emergency care would apply.

The chart in proposed Section .05(C) includes an appointment waiting time standard for "non-urgent specialty care" visits. We believe the Insurance Administration will need to clarify which specialty types should be included in this measure and if it should be calculated as an average across all included specialty types. Additionally, we again recommend that the Insurance Administration apply these wait time standards only to initial appointments/ consultations, as follow-up or ongoing care is often scheduled in advance and would skew the measurement of wait times.

.07 Waiver Request Standards.

We recommend that the Insurance Administration amend Section .07(B) as follows:

> **A. A carrier may apply for a network adequacy waiver, for up to 1 year, of a network adequacy requirement listed 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 the physicians, other providers or health care facilities necessary for an adequate network:**
>
> **(~~1~~a) Are not available to contract with the carrier;**
> **(~~2~~b) Are not available in sufficient numbers;**
> **(~~3~~c) Have refused to contract with the carrier; or**
> **(4d) Are 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 reasonably demonstrates that its integrated delivery model ensures adequacy, accessibility, transparency and quality of health care services.***

COMMENT: The language in Section .07 allows carriers to apply for a waiver from one or more of the network adequacy requirements in *COMAR 31.10.44*. While Kaiser Permanente supports and appreciates the inclusion of waiver language, the bases on which the Commissioner may find good cause to grant a waiver only speak to the ability of the carrier to contract with providers. These bases do not extend to reasons why a group model HMO might request a

waiver, such as that meeting the standard would require contracting with providers who are not able or willing to participate in the integrated electronic health record in order to ensure care coordination and quality. As currently written, this subsection does not allow group model HMOs to seek a waiver without fundamentally changing how they provide care to their members. Kaiser Permanente requests that the language in Section .07 be amended as shown above so it is applicable to all carriers including group model HMOs.

.09 Network Adequacy Access Plan Executive Summary Form.

We recommend that the Insurance Administration amend Section .09(A)(1)(d) and (e) as follows:

(1) Travel Distance Standards.

(a) List the percentage of the participating providers, by primary care provider and specialty provider type, for which the carrier met the travel distance standards listed in Regulation .04 of this chapter, in the following format:

	Urban Area	**Suburban Area**	**Rural Area**
Primary Care Provider			
Specialty Provider			

(b) List the total number of certified registered nurse practitioners counted as a primary care provider.

(c) List the total percentage of primary care providers who are certified registered nurse practitioners.

(d) *For non-group model HMOs*, list the total number of essential community providers in the carrier's network.

(e) *For non-group model HMOs*, list the total percentage of essential community providers available in the health benefit plan's service area that are participating providers.

COMMENT: If Kaiser Permanente's proposed amendment to Section .04(C) (related to Essential Community Providers) is adopted by the Insurance Administration, Kaiser Permanente would be required to meet an alternative ECP standard using its own providers, and the reporting requirements in Section .09(A)(1)(d) and (e) would not apply to group model HMOs.

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.

At a minimum, Kaiser Permanente believes the language in proposed *COMAR 31.10.44 Network Adequacy* should be revised and clarified as follows:

1. Definitions and Travel Distance Standards - Clarify the definitions of "rural area," "suburban area" and "urban area" in Section.02(B)(19), (21) and (24) to specify what is meant by the term "region." Without this specific information, Kaiser Permanente is unable to analyze the impact of the distance standards that are included in Section .04(B)(4)*;* and, as a result, our comments related to Section .04(B)(4) are limited and incomplete.

2. Travel Distance Standards - Amend Section .04(B)(1) to include a 80% threshold for group model HMOs in the travel distance standards to reflect members' growing preference for telehealth services.

3. Travel Distance Standards - Amend the travel distance standards in Section .04(B)(4) to adjust specific distances for group model HMOs to reflect the important differences in how health care is delivered through Kaiser Permanente's integrated delivery system.

4. Essential Community Providers - To comply with state law, amend Section .04(C) by including an alternative ECP standard for group model HMOs. 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* is the best approach to meet the alternative ECP requirement that is mandated in state law.

5. Appointment Waiting Time Standards – Amend Section .05(A) to reduce the threshold to 80%.

6. Appointment Waiting Time Standards - Amend Section .05(C) to increase the waiting time standard for non-urgent mental health/substance use disorder services to 15 calendar days to align with the standard for primary care. Non-urgent mental health/substance use disorder services do not require a shorter waiting time standard than primary care or any other type of care. If a member requires urgent or emergency mental health services, the timeframes for urgent or emergency care would apply.

7. Waiver Request Standards – Amend Section .07 so the bases for finding "good cause" to grant a waiver may also include factors appropriate to group model HMOs whose model of health care delivery and provider network structure are significantly different than health plans who contract with numerous providers.

Kaiser Permanente appreciates the Insurance Administration'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.