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

September 1, 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 September 1, 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 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 1,400 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 our 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 "primary care provider-to-enrollee ratios" (§15-112(D)(2)(III)) and "provider-to-enrollee ratios, by specialty" (§15-112(D)(2)(IV)), which are the focus of the September 1, 2016 public hearing. The MIA is also soliciting feedback as to whether to modify ratios for providers who contract with more than one carrier and for health plans with such characteristics as having centralized provider offices or requiring a primary care appointment before referral to a specialist.

General Comments on Provider-to-Enrollee Ratios

Kaiser Permanente believes that health plan enrollees should have appropriate and timely access to high-quality, affordable care. While provider-to-enrollee ratios are frequently used across the

industry as a measure of access, they 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 performance, member satisfaction and appointment availability, 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 our 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. These key distinctions are discussed in more detail in the sections below. 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.

Primary Care Provider-to-Enrollee Ratios

Most provider-to-enrollee ratio standards used in the market today focus on primary care, with ratios ranging widely from state to state and even between insurance markets within states (e.g. Commercial vs. Medicaid). Given Kaiser's focus on primary and preventive care, we agree that it is important to have an adequate supply of primary care providers (PCPs) for the members of a health plan. However, the way in which care is arranged or provided contributes heavily to the number and types of providers needed for the plans' membership.

In the case of Kaiser, two key distinguishing factors are important to consider.

First, for the vast majority of our members, primary care is provided by physicians and other professionals employed by the Mid-Atlantic Permanente Medical Group (MAPMG) or by Kaiser Foundation Health Plan, and our PCPs do not contract with other payers. This means they are available virtually exclusively to Kaiser members. Therefore the "1" PCP as represented in a ratio truly means a whole full time equivalent provider. Essentially, a primary care ratio in the context of our model is equivalent to a primary care panel. Our approach to hiring/staffing is based upon PCPs' optimal panel size to deliver high quality care with appropriate access for our actual and forecasted membership. This is in contrast to network-model carriers, where a single network provider may have contracts with several other carriers, so his or her true availability to the members of a given health plan is unknown. In light of this distinction, any primary care ratio determined by MIA should be appropriately adjusted to take into account the full availability of our PCPs to Kaiser members. Failing to adjust such a ratio accordingly would result in inefficient use of health care resources due to the resulting excess capacity in our provider panels.

Second, in our integrated system of care delivery, we use team-based care, organized clinical workflows and our integrated electronic health record, and we seek to optimize our clinicians'

and professionals' full scope of practice. For example, for our members with diabetes, we monitor them based on their HgA1C levels, and depending on the level and amount of support that they need, in addition to their primary care physician, they are also followed by either a nurse, clinical pharmacist or nurse practitioner. The clinical work is shared among team members, and all clinicians are connected through our shared electronic health record. Such planning, connectivity and coordination yields efficiencies in care delivery that can reduce the need for the higher staffing levels.

If the MIA decides to adopt primary care provider-to-enrollee ratios for the Commercial and Exchange markets, it should ensure that the ratios are set appropriately to acknowledge that most providers contract with multiple carriers and that the ratios are adjusted to accommodate integrated care delivery models like Kaiser's.

Specialty Care Provider-to-Enrollee Ratios

Specialty provider-to-enrollee ratios are less common across states but again vary greatly from state to state in terms of the specialties of focus and the number of providers required. In general, we believe health plans are in the best position to determine the specialty care needs of their membership, depending on their claims experience and disease burden. Therefore, we would not recommend the adoption of specialty ratios.

However, if MIA wishes to consider specialty ratios, it should account for the varying supply and availability of different types of specialty providers across Maryland. For example, in more rural counties such as Calvert and Charles, there are shortages of both primary and specialty care physicians. It is important that any ratios take such supply issues into account. MIA should also take into account the growing availability of telemedicine and other forms of remote access to care. In our system, for example, members are able to directly access their primary and specialty care providers via telephone appointments, secure email and, increasingly, live video consultations. While these technologies cannot and should not fully replace in-person visits, they are helping extend access to high quality care for all members.

MIA also needs to consider the important differences in integrated systems like Kaiser. As in the primary care context, a large percentage of our specialists are employed by MAPMG and do not contract with other carriers, meaning that they are fully and exclusively available to our members. Additionally, our organized clinical workflows, use of technology and team-based care yield efficiencies that often means fewer specialists are needed to provide the same level of access and high-quality care as a higher number of specialists contracted with a network-model carrier. We optimize the productivity and efficiency of our physicians through the use of technology and collaboration, from phone consultations between specialists to chart review between the primary care and specialty care teams, to phone or video consultations directly between the patient and the specialist. Differences in care organization and delivery are critical to recognize, should MIA wish to adopt provider-to-enrollee ratios.

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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.