KAISER PERMANENTE®

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

June 2, 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 Comments on Topics for June 2, 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 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 criteria the MIA may take into consideration in adopting the regulations, including "any standards adopted by the federal Centers for Medicare and Medicaid Services [CMS] or used by the Federally-Facilitated Marketplace [FFM]" (§15-112(D)(2)(X)) and "any standards adopted by another state" (§15-112(D)(2)(XI). The development of these network adequacy criteria is the subject of the June 2, 2016 public hearing.

Our comments focus on the federal standards in place for the Medicare Advantage program and the review criteria being used for the FFMs in 2017. Specifically, CMS uses a stringent set of county-level drive time and distance standards for Medicare Advantage and proposed, but did not finalize, the adoption of a similar time and distance standard as the default standard for FFM states whose network adequacy evaluation does not meet CMS requirements. For the 2017 plan

101 East Jefferson Street
Rockville, Maryland 20852

year, CMS will instead continue to apply a "reasonable access" standard to evaluate provider networks for plans offered in the FFMs, and will do so by testing the networks against a subset of the Medicare Advantage time and distance standards.

Kaiser urges the MIA not to adopt time and distance standards akin to those used in the Medicare Advantage program and applied to FFMs for 2017 evaluation.

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 time and distance standards like those used for Medicare Advantage and the FFMs would do very little to achieve that goal. While they are quantifiable and common across the industry, time and distance standards have the following significant flaws as a measure of health care access:

- they do not ensure that enrollees can actually access 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; and
- they work against integrated care delivery by forcing plans to maintain a highly geographically distributed provider network.

For these reasons, discussed in more detail below, the MIA should not adopt the federal network adequacy standards being used in Medicare Advantage and the FFMs.

Time and distance 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 open 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 access care from the appropriate provider.

Time and distance 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.

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. Within patient-centered medical home models there is typically 24-hour access to clinical advice by telephone. These remote methods

of delivering 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 enrollees. 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.

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 often co-locate our providers and facilities so that our members can see multiple providers, fill their prescriptions and receive ancillary services such as lab and imaging in a single visit. Additionally, through our integrated model, our providers can consult with colleagues and better coordinate care through appropriate multispecialty provider coverage and centers of excellence. 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.

We strongly oppose the adoption of the federal time and distance standards for the reasons detailed above. While the location of providers and facilities is relevant for enrollees, there are other, more meaningful factors MIA should consider in developing network adequacy standards, including quality, member satisfaction, timeliness and availability of appointments, access to care through remote options like telemedicine, and the convenience of co-located services. We plan to provide further detail on these and other factors throughout the MIA's rulemaking process.

---

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

* * *

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.