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Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

August 8, 2022

Kathleen Birrane
Commissioner
Maryland Insurance Administration
200 St. Paul Place
Baltimore, MD 21202

Submitted electronically via: networkadequacy.mia@maryland.gov.

RE: Kaiser Permanente Comments on Network Adequacy Regulations

Dear Commissioner Birrane:

Thank you for the opportunity to provide comments on the draft network adequacy regulations. We appreciate the MIA incorporating many of the changes that we requested in our December 2020 comment letter. We recognize that reviewing and considering all stakeholder feedback on these regulations is a labor-intensive process, so we especially appreciate the work of MIA staff to manage the stakeholder engagement in a thoughtful way.

Kaiser Permanente is committed to providing our members with timely and convenient access to the health services that they need. The National Committee on Quality Assurance ("NCQA") has rated KP's mid-Atlantic commercial health plans as among the top 1% in the nation—and the best in Maryland. NCQA evaluates health plans on the quality-of-care patients receive, patient satisfaction, and health plans' efforts to keep improving. We are proud that our members receive superior care at Kaiser Permanente in Maryland.

Our comments on the latest draft regulations are attached to this letter. We would be happy to discuss them with the MIA at any time, if desired. Please feel free to contact me at Allison.W.Taylor@kp.org or (202) 924-7496 with questions.

Sincerely,

Allison Taylor

Allison Taylor
Director of Government Relations
Kaiser Permanente

.03 Network Adequacy Standards.

- **.03A(5):** This paragraph requires a carrier to monitor the availability of services for continuity of care. We agree that it is important for our members, including those with continuity of care needs, to have access to the care they need. However, we're not clear on what "continuity of care" specifically means in this context or how it differs from our responsibility to meet the travel distance and waiting times standards for all appointments, whether they be a patient's first or a follow-up appointment with a provider. To the extent this requirement is vague or duplicative, we suggest removing it.

[.03] .*04* Filing *and Content* of Access Plan.

- **.04C(3)(d):** This subparagraph requires a carrier to report various metrics related to non-participating providers. While a high rate of out-of-network claims may help identify a network deficiency, the data required by this subparagraph would not account for member preferences, e.g., to see a non-participating provider even if an in-network provider is available. We recommend removing this requirement.

- **.04C(3)(f)(8):** This provision requires us to report on whether our network directory is searchable by covered benefit, and the language provides the examples of "hand physical therapist" and "specific durable medical equipment." We recommend including examples that are more reflective of covered benefits and provider types and recommend a revision such as: An indication of whether the network directory is searchable by covered benefit or provider type, for example, hearing aid, knee surgery, or physical therapist.

- **.04G:** We are wondering if this subsection includes an incorrect cross-reference. This subsection requires a group model HMO plan to report the requested geographic area data described in §C(3) of this regulation *based on the enrollee's place of employment*, if the enrollee gains eligibility for participation in the plan due to place of employment. §C(3) of this regulation does not appear to reference geographic access data.

  Kaiser Permanente would also like to further understand why the MIA is seeking information based on place of employment. For enrollees who have dependent coverage or are covered under an individual policy, we would not necessarily know if or where they are employed. We also question why this requirement is not applied to all carriers. We request that this requirement be removed, or at a minimum, revised to read as follows:

  G. (1) For a Group model HMO plan, the geographic area data described in [updated cross-reference] shall be reported based on the enrollee's place of residence or place of employment, if the enrollee gains eligibility for participation in the plan due to place of employment.

  (2) When calculating the number or percentage of enrollees with a place of employment within a geographic area, the carrier shall include only those enrollees who gain eligibility for participation in the group model HMO's health benefit plan from their place of employment.

[.04] .05 Travel Distance Standards.

- **.05B(5):** We appreciate that the MIA removed the "gynecology only" category from the chart of travel distance standards in .05B(5). Kaiser Permanente previously commented that this category is duplicative of the "Gynecology, OB/GYN" category.

- **.05B(5):** This paragraph adds the category "physician certified in addiction medicine." We recommend changing this term to "addiction medicine." This change would make the language more consistent with the other provider types listed and is more reflective of the holistic approach to substance use treatment that we provide at Kaiser Permanente.

[.05] .06 Appointment Waiting Time Standards.

- **.06A(3) through (6):** Kaiser Permanente supports developing a methodology to better capture waiting time data. However, we do not think the survey tool or direct contact with a random selection of providers is the most efficient way for carriers to collect and report information about our networks. This is based on our experience in California, where we are required to complete a similar survey; each carrier contracts with its own vendor to survey providers about waiting times twice annually, on dates chosen by the carrier. Many of the survey parameters are left up to the carriers to determine, meaning each carrier's results are based on its own internal assumptions. We often get a very low response rate, which jeopardizes the integrity of the findings. There is a substantial body of evidence showing that individuals' retrospective self-reports are unreliable.

  We propose the following revision, which would more reliably capture waiting times:

  The Commissioner shall conduct an annual survey to measure waiting time, by carrier, for each appointment type listed in §A(2) of this regulation.
  (a) The survey shall:
  (i) make direct contact with a random selection of providers qualified to provide the services for each of the appointment types listed in §A(2) of this regulation to ask for next available appointments; and
  (ii) use statistically reliable and valid methodology.
  (b) The Commissioner may:
  (i) contract with a vendor to conduct the survey; and
  (ii) charge a carrier a reasonable fee to cover the costs of the survey.
  (c) The Commissioner shall publish the methodology used to complete the survey.

- **.06B(2):** Kaiser Permanente objects to the removal of this paragraph, which enables a carrier to include telehealth appointments in the waiting times standards *when it is clinically appropriate and an enrollee elects* to do so. The qualifying language in this paragraph already protects patients by prohibiting a carrier from including this data if a patient chooses not to accept a telehealth appointment. The expansion of telehealth services during the pandemic has vastly changed health care delivery, and exclusion of

those services from the waiting times standards would not give the MIA an accurate picture of patient access.

- **.06E:** Consistent with the urgent care standard for medical services, we recommend that the "inpatient urgent care" and "outpatient urgent care" for mental health and substance use services be combined. Kaiser Permanente offers walk-in urgent care services for members with behavioral health needs, at which point a plan of care is developed that may include outpatient or inpatient treatment. Treatment of these as separate categories does not represent our model of care.

.08 Telehealth

- **.08A(2) and D(1):** These provisions require a carrier to make calculations based on an enrollee's place of residence or, for a group model HMO, place of employment from which the enrollee gains eligibility for participation in the health benefit plan. Is this language intended to require a group model HMO to conduct this calculation based on an enrollee's place of employment only, or could the group model HMO also use an enrollee's residence? Consistent with elsewhere in the regulations, we request a clarification that either location may be used.

- **.08B:** Kaiser Permanente supports the addition of a telehealth credit for the travel distance standards. This credit aligns with the credit provided by CMS in the Medicare Advantage program.

- **.08C:** In order to make sure that we understand how to apply the appointment waiting time telehealth credit, Kaiser Permanente requests that the MIA provide an example fact pattern and analysis. The example below describes our understanding of the provision, and we want to make sure our reading is aligned with that of the MIA.
    - A carrier conducts the survey required by .06A(3) and determines that it met the waiting time standard of 15 calendar days for in-person routine primary care 86% of the time. By itself, this falls short of the carrier's obligation to meet the standard for at least 90% of routine primary care appointments, which is established in .06B(2).
    - The carrier also offers telehealth appointments for routine primary care. The carrier could apply for a telehealth credit of 4% in order to meet the 90% threshold.
    - The Commissioner may approve the credit if a carrier successfully demonstrates it meets the requirements outlined in .08C(3).

Final Comment: We anticipate that much of the new data requested by the MIA in these regulations will assist the agency in developing a broader picture of healthcare availability in Maryland. We hope that the MIA will share high-level trends and conclusions with us as part of an ongoing dialogue about our access plan filings so we can continue to improve our members' access to care.