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Mid-Atlantic Permanente Medical Group, P.C.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

December 4, 2020

Kathleen Birrane
Commissioner of Insurance
Maryland Insurance Administration
200 St. Paul Street, Ste. 2700
Baltimore, MD 21202

Comments submitted electronically via networkadequacy.mia@maryland.gov.

RE: Kaiser Permanente Comments on Network Adequacy Regulations

Dear Commissioner Birrane:

Kaiser Permanente appreciates the opportunity to provide comments on the network adequacy regulations. Kaiser Permanente is one of the largest private integrated health care delivery systems in the United States, delivering health care to over 12 million members in eight states and the District of Columbia.[1] In Maryland, we deliver care to over 440,000 members. These comments are offered jointly by Kaiser Foundation Health Plan of the Mid-Atlantic States (KFHP-MAS) and Kaiser Permanente Insurance Company (KPIC), which both file Access Plans to the MIA.

Kaiser Permanente is committed to providing a robust network for our members, and we appreciate the opportunity to work with the MIA on these regulations. We have outlined areas of major concern below, and where possible, proposed alternatives. We look forward to meeting with you on December 21, when we can discuss some of these items in detail.

Thank you for consideration of this information. If you need additional information, please contact me at Wayne.D.Wilson@kp.org or (301) 816-5991 with questions.

Sincerely,

Wayne D. Wilson
Vice President, Government Programs and External Relations
Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.

[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., one of the nation's largest not-for-profit health plans, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

Kaiser Permanente Comments to Proposed Network Adequacy Regulations

Regulation .02: Definitions

.02B(2): Regulation .02B(2) adds a new definition of "ambulatory infusion therapy center"; this term replaces "outpatient infusion/chemotherapy" as a facility that's required to meet the travel distance standards. Thank you for clarifying at our December 2 meeting that this change is intended to be more inclusive. We propose a small change to the definition to read "any location that administers chemotherapy or infusion services on an outpatient basis." This change removes the requirement that such facilities be "authorized" to administer chemotherapy or infusion services; we are not aware of an entity in Maryland that "authorizes" a facility to administer these services.

.02B(29): Kaiser Permanente supports altering the definition of "telehealth" to align with section 15-139 of the Insurance Article so that it includes delivery of mental health care services to a patient in the patient's home setting. We would also like to see the definition account for the telehealth flexibilities that have been afforded through the COVID-19 pandemic, such as an audio-only telephone conversation between a health care provider and a patient. We recommend that the MIA include these flexibilities in the definition or otherwise issue guidance that appointments offered in this manner may count toward a carrier's compliance with the waiting time standards.

Regulation .03: Network Adequacy Standards

.03A(6): Kaiser Permanente recommends removing the language in regulation .03A(6) that requires a carrier to report, by zip code, the number of providers in certain board specialties. Kaiser Permanente physicians provide care at 18 facilities across Maryland and will travel as needed. As we continue to provide more and more care through telehealth, the physical location of these providers will be much less important as patients have many ways to access care. However, the data we would provide under this regulation would tie each provider to their primary work location, which wouldn't accurately reflect the availability of providers for patients.

.03B(1): Kaiser Permanente continually monitors its provider network for compliance with network adequacy and other requirements; however, a full review requires substantially longer than one month to ensure that all requirements are met and to remedy any deficiencies. We recommend that the requirement to monitor the network for compliance be changed from "monthly" to "bi-annually."

Regulation .04: Filing of Access Plan

.04C(5)(b): Kaiser Permanente recommends removing this language. We don't have access to this information and would not without substantial assistance from the hospitals. To the extent the MIA is interested in assessing consumers' exposure to balance billing, we propose that

carriers could submit membership and claims information for Emergency Departments in Maryland. Kaiser recently completed a similar request for this information from the Virginia Bureau of Insurance to assist them in assessing the impact of balance billing. If the MIA is interested in pursuing this alternative, we'd proposed that it need not be included in the regulations but could be a separate request.

Regulation .05: Travel Distance Standards

95% Threshold: Kaiser Permanente believes that a threshold of 95% compliance with the travel distance standards should be used, consistent with the standards for waiting time. For the vast majority of provider groups across urban, suburban, and rural jurisdictions, KP meets the travel distance standards for 100% of members. However, there are a few provider types for which compliance is slightly lower but at least 95%. Under current regulations, we would be out of compliance if we did not meet the distance standards for even one type of provider. Given KFHP-MAS's near-complete compliance, we believe that the leeway afforded by a 95% threshold would give us adequate flexibility to adapt to changing market conditions without compromising the integrity of the program. To that end, Kaiser Permanente recommends the following revisions:

- **.05A(1)(a):** Except as stated in §B of this regulation, each provider panel of a carrier shall have within the geographic area served by the carrier's network or networks, sufficient primary care physicians, specialty providers, **[**behavioral**]** *mental* health and substance use disorder providers, hospitals, and health care facilities to meet the maximum travel distance standards listed in the chart in §A(5) of this regulation for at least 95 percent of enrollees for each type of geographic area.

- **.05B(1)(a):** 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, **[**behavioral**]** *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(5) of this regulation for at least 95 percent of enrollees for each type geographic area.

Telehealth Credit: We also recommend that the MIA consider providing a telehealth credit toward meeting the travel distance standards, similar to the credit provided by CMS in the Medicare Advantage program. The CMS language is as follows, and we would be happy to work with the MIA on language that's appropriate for Maryland.

> *Organizations will receive a 10% credit towards the percentage of beneficiaries that must reside within required time and distance standards when they contract with telehealth providers in the following specialties: Dermatology, Psychiatry, Cardiology, Otolaryngology, Neurology, Ophthalmology, Allergy and Immunology, Nephrology, Primary Care, Gynecology/ OB/GYN, Endocrinology, and Infectious Diseases.*

.05A(1)(b(ii): Kaiser Foundation Health Plan of the Mid-Atlantic is currently able to measure travel distance standards based on "road travel distance." However, Kaiser Permanente Insurance Company, uses an outside vendor for this service. The vendor's software measures travel distance consistent with the methodology accepted in other states and cannot currently calculate these standards in this manner.

.05B(1)(c) and (d): These regulations require a carrier to map and analyze geographic areas within zip codes that fall outside the travel distance standards. Since KP and other carriers are already in near-complete compliance with these standards, we recommend that efforts toward further analysis be focused elsewhere in the regulation. To that end, we recommend removing regulations .05B(1)(c) and (d).

.05B(1)(e)(i): Consistent with our comment above, we recommend removing the language "and identifying any geographic areas within each zip code where the applicable distance standard is not met".

.05B(1)(e)(ii): We understand that access to health services can be difficult for individuals that do not own a personal automobile; however, we believe the analysis required by this regulation would be better performed by an entity with expertise in transportation planning, rather than a carrier. We recommend removing regulation .05B(e)(ii).

.05B(4): KFHP-MAS meets the travel distance standards for the specialties listed in this provision –physical therapists, nutritionists, and dietitians – and does not object to this revision. We recommend changing the distance standards of 15 miles for Urban Areas, 40 miles for Suburban Areas, and 90 miles for Rural Areas to 20 miles for Urban Areas, 40 miles for Suburban Areas, and 90 miles for Rural Areas. This change would correct an inconsistency by aligning this provision with what's listed in the chart in .05B(5) (see the line "All other licensed or certified providers under contract with a carrier not listed").

.05B(5): *Providers:* We recommend changing the term "physician certified in addiction medicine" 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. We are not concerned about the addition of child psychiatry, geriatric psychiatry, licensed professional counselors, nutritionists/dieticians, or physical therapy.

Facilities: Consistent with our comment to Regulation .02B(2), Kaiser Permanente does not object to the replacement of the "outpatient infusion/ chemotherapy" standard with "ambulatory infusion therapy center" since this intent is for the new term to be more inclusive. Thanks again to MIA staff for clarifying that.

Regulation .06: Appointment Waiting Times

Terminology: Regulation .06 alternately refers to "waiting time" and "wait time." We recommend standardizing the terms used.

.06A(2): As drafted, this regulation requires each carrier to make available to its members the median wait times to obtain certain appointments with a participating provider within the applicable maximum travel distance standards. This would require Kaiser Permanente to conduct a separate analysis for every member, for every provider. As discussed at our December 2 call, this requirement is onerous and expensive, and we anticipate substantial staff time and IT investment would be required to comply. If the MIA is interested in carriers providing wait time information to members on a quarterly basis, we recommend that the regulation require reporting of wait times for the service area as a whole.

.06A(3) through (6); .06B(1): 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 opinion 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 is own internal assumptions. Additionally, we often get a very low response rate, which jeopardizes the integrity of the findings. Despite these concerns, we have a number of potential alternative solutions, which we can discuss with you at our December 21 meeting. If any of the suggestions are suitable to the MIA, we'd be happy to draft proposed language for the regulations.

.06B(2): We read this section to mean that the 10-day notification window would be triggered by the quarterly analysis of our provider panel required by regulation .06A(2). We request that the MIA clarify when the reporting requirement is triggered.

.06B(3): Kaiser Permanente supports the change permitting the offer of a telehealth appointment to be counted toward the waiting time standards.

.06D: We believe the intent of this section is that a follow-up visit for a chronic condition that is set for a longer period of time than the standard wait time suggests does not count against a carrier. If our interpretation is correct, Kaiser Permanente supports this addition to the regulations. However, we would appreciate clarification from the MIA.

.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 make sense for our system.

.06F: We recommend that if the MIA wants to receive a list of complaints relating to the unavailability of a provider, it be provided annually as part of the access plan, rather than quarterly.

Regulation .07: Provider-to-Enrollee Ratio Standards

Kaiser Permanente has no comments on the changes to this regulation.

Regulation .08: Network Adequacy Waiver Standards

.08A(2): Kaiser Permanente does not primarily build its network through provider contracting, so we request the following change to this regulation to reflect our model: "(2) An explanation of how many providers in each specialty or health care facility type that the carrier reasonably estimates it would need to contract with or otherwise include in its network to satisfy each unmet standard".

Regulation .09: Confidential Information in Access Plans

.09A: Kaiser Permanente interprets this change to mean that the methodology required by regulation would not be confidential, but any methodology we develop to further implement regulations (e.g., survey questions and protocols) would remain confidential. If this is the case, we have no objection to the change.

Regulation .10: Network Adequacy Access Plan Executive Summary Form

Kaiser Permanente has no comments on the changes to this regulation.

Effective Date

Kaiser Permanente requests that the MIA establish a phased implementation schedule or a delayed effective date for these regulations. Kaiser Permanente is committed to providing a robust network for our members and like all health care providers, we are adapting rapidly to the changing conditions provided by the COVID-19 pandemic. In particular, we would find it nearly impossible to comply with all of these changes in time to submit the July 1, 2021 access report. A phased implementation schedule or delayed effective date would allow us time to make the operational changes necessary to comply with the regulations and afford the MIA time to make additional adjustments as market conditions continue to evolve.

Thank you for your consideration of these comments and we look forward to working with you as this process moves forward.