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

August 19, 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 regarding 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] Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., which operates in Maryland, provides and coordinates complete health care services for approximately 770,000 members. In Maryland, we deliver care to over 440,000 members.

At the August 5, 2020 meeting of the Network Adequacy Workgroup, the MIA facilitated discussion around two sets of questions that were originally posed to the Workgroup in the fall of 2019. KP's written responses to the first set of questions, "MIA Staff Questions to Interested Parties," are in Appendix 1, and the responses to the second set, "Discussion topics from October 23, 2019 meeting and other matters related to COMAR 31.10.44," are in Appendix 2. We have provided a few additional comments in Appendix 3.

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.

Appendix 1: MIA Staff Questions to Interested Parties

In the definitions section in COMAR 31.10.44.02, should a definition for any of the provider types listed in the travel distance standards be included?

Kaiser Permanente does not believe that additional provider types need to be defined in the definitions section, COMAR 31.10.44.02.

Do the charts of travel distance standards in COMAR 31.10.44.04 include the appropriate mix of providers? Should any providers be added (e.g. child psychiatrist) or removed, and why?

The standards include in its list of providers both "primary care physician" and "pediatrics-routine/primary care." Kaiser Permanente would like clarification if there is intended to be overlap in these two categories. Otherwise, we have no suggested changes for the list of providers.

Are the current mileage metrics for the travel distance standards in COMAR 31.10.44.04 appropriate?

Kaiser Permanente believes the mileage metrics are appropriate and does not recommend a change.

Should carriers be required to comply with the travel distance standards for 100% of enrollees, or should the threshold be 95% to be consistent with the appointment waiting time standards, and why?

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 98%. Under current regulations, we would be out of compliance if we did not meet the distance standards for even one type of provider. Given our 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.

Should the regulations be revised to require that travel distance standards are based on "road travel distance"? Why or why not?

Kaiser Permanente calculates travel distance based on the distance a member must travel on roads to reach the provider or facility. To that end, we believe that specifying that the standards are based on "road travel distance" would not impact our compliance with the standards.

For enrollees covered under student health plans, should the regulations mandate or allow that the school's address be used for determining travel distance standards?

Kaiser Permanente does not offer student health plans and so has no position on this question.

For the essential community provider standard, COMAR 31.10.44.04C requires that a provider panel "shall include 30 percent of the available essential community providers in each of the urban, rural, and suburban areas." Should the regulation be revised to require a standardized methodology for calculating the 30% inclusion standard by geographic region?

Kaiser Permanente is a group model HMO plan and so is not subject to this requirement.

Should carriers be required to provide a list of all contracted ECPs within their network for each provider panel?

Kaiser Permanente is a group model HMO plan and so is not subject to the requirement to contract with ECPs.

Should the regulations require a standardized methodology to measure wait time standards, and if so, what methodology?

Kaiser Permanente is committed to providing access to care within the wait times established by the network adequacy regulations. For appointments with our Mid-Atlantic Permanente Medical Group (MAPMG) providers, appointment supply and demand are monitored on a daily, weekly and monthly basis for all appointment types at each Kaiser Permanente medical facility. Kaiser Permanente routinely surveys its contracted providers to determine whether they are meeting appointment accessibility standards. Inability to meet access standards may result in removal from the participating provider network.

Kaiser Permanente believes the regulatory definitions create a standardized methodology to measure wait times. The regulations require a health plan to meet the waiting time standards listed in COMAR 31.10.44.05C for at least 95 percent of the enrollees covered under health benefit plans that use that provider panel. The regulations define "waiting time" as "the time from the initial request for health care services by an enrollee or by the enrollee's treating provider to the earliest date offered for the appointment for services." Kaiser Permanente believes this is the correct standard and that all plans should measure wait times as defined. As such, KP recommends no change to the regulations.

Are the current time period metrics for the waiting time standards in COMAR 31.10.44.05 appropriate based on the availability of healthcare providers in Maryland?

Kaiser Permanente believes that the metrics for the waiting time standards are appropriate. We have consistently met or exceeded the metrics for urgent care, routine primary care, preventive visits, non-urgent specialty care, and non-urgent ancillary services. In 2020, we reported 75% compliance with the 10-day standard for non-urgent behavioral health and substance use services and submitted a waiver request for that standard.

As noted in our waiver request, our appointment supply for non-urgent behavioral health/substance use disorder services is adequate and available for members willing to schedule an encounter with a Plan Provider within the 10-calendar-day period required by regulation. However, patient preference and their personal choice to decline an earlier appointment and seek services at a later date that is more convenient or with a preferred provider impacts the way waiting times are reported in our system. Rather than recommending a change to the standard, we are looking for ways to modify our data collection that better reflect our compliance with the standard.

We do think the flexibility offered by waivers remains important in the behavioral health field because of the availability of these providers. We are facing a national shortage in the behavioral health workforce. One in five American adults has a diagnosable mental illness, yet there is a severe mental health provider shortage in most counties in the United States. In the face of a statewide and nationwide shortage of mental health providers, Kaiser Permanente has hired hundreds of providers in the Mid-Atlantic region and is investing millions to expand postgraduate training programs and advance the education and experience of its therapists and others who intend to join the behavioral health profession. In the past five years, Kaiser Permanente has increased the number of psychotherapists across the region by 56% and the number of psychiatrists by 36% and continues to aggressively hire more – despite the shortage. Through an intentional and concerted effort, we have increased the percentage of African American psychotherapists specifically across the region by 142%. We are proud of these results. However, as this remains an area where market conditions are challenging, we ask you to maintain flexibility.

House Bill 599 of the 2019 legislative session, effective January 1, 2020, requires carriers to use the most recent edition of the American Society of Addiction Medicine treatment criteria ("ASAM criteria") for all medical necessity and utilization management determinations for substance use disorder benefits. Are revisions to the network adequacy regulations in COMAR 31.10.44 necessary to ensure that a carrier's network is sufficient to provide coverage at all levels of care indicated by the ASAM criteria? If so, what specific standards or metrics should be established based on the ASAM criteria?

Kaiser Permanente uses the ASAM criteria for medical necessity and utilization management determinations for substance use disorder benefits in accordance with House Bill 599 of the 2019

session. As such, we do not believe that further specificity in the regulations is necessary to comply with this legislation.

It has been noted that the definition of "essential community provider" in the plan certification regulations for the Maryland Health Benefit Exchange expressly includes school-based health centers, but the corresponding definition in the network adequacy regulations for the Maryland Insurance Administration does not. Are there any potential adverse consequences for consumers or significant carrier concerns with revising the essential community provider definition in COMAR 31.10.44.02B(6) to expressly include school-based health centers?

Kaiser Permanente is a group model HMO plan and so is not subject to the requirement to contract with ECPs. As such, we have no position on this question.

Appendix 2: Discussion topics from October 23, 2019 meeting and other matters related to COMAR 31.10.44

Filing of Access Plan (COMAR 31.10.44.03)

- Are there any concerns or problems with the filing process itself?
- Are clarifications needed for any of the existing requirements?

Kaiser Permanente is satisfied with the process for filing the access plan and does not recommend any changes to the regulations.

Network Adequacy Access Plan Executive Summary Form (COMAR 31.10.44.09)

- Would a standardized reporting form be helpful to carriers and the public?
- Should the executive summary form identify whether the carrier has requested a waiver for any standard?
- Should the items required on the executive summary form be expanded or narrowed?
- Are clarifications needed for any of the existing requirements?
- Other comments about the executive summary form?

Kaiser Permanente would have no problem using a standardized reporting form and believes it could be helpful to the public when comparing plans. Similarly, we would be fine with a change to the regulation to identify whether a carrier has requested a waiver for any standard. Otherwise we believe the items required on the executive summary form should not be expanded, in order to protect confidentiality of other data reported to the MIA.

Waiver Request Standards (COMAR 31.10.44.07)

- Should waiver requests be mandatory when a carrier fails to satisfy a standard?
- Should a standardized waiver request form be developed?
- Should the reasons for which the Commissioner may grant a waiver request under COMAR 31.10.44.07B be expanded or narrowed?
- Should the information required to be submitted with a waiver request under COMAR 31.10.44.07C be expanded or narrowed?
- Are clarifications needed for any of the existing requirements?
- Other comments about the waiver request standards?

Kaiser is satisfied with the language in COMAR 31.10.44.07A permitting a carrier to apply for a waiver from a network adequacy requirement and thinks that a standard form is not necessary. In many cases, a carrier may benefit from the opportunity to explain the circumstances necessitating a waiver in a flexible manner.

Kaiser Permanente requests that the requirements under COMAR 31.10.44.07B and C be expanded or revised to better define how the requirements apply to a group model HMO. These regulations contemplate a scenario where a carrier has built a network solely through provider contracting. However, KP members receive the majority of their services from our MAPMG

physicians and our Health Plan professional staff. The regulatory language could be adjusted to reflect this type of arrangement, and we would be happy to work with the MIA on appropriate language.

Confidential Information in Access Plans (COMAR 31.10.44.08)

- Should the list of specific items the Commissioner considers confidential under COMAR
- 31.10.44.08A be expanded or narrowed?
- Are clarifications needed for any of the existing requirements?
- Other comments about confidentiality?

Kaiser Permanente strongly advocates that the list of specific items considered confidential should not be narrowed. The regulations already provide that the most relevant information – the carrier's compliance with the distance, waiting time, and provider ratio requirements – is available to the public. The multi-year workgroup process has allowed for a healthy debate about what methodology should be calculate these metrics, and the MIA will take this under advisement as it considers additional revisions of the regulations. However, a carrier should continue to have the opportunity to further explain its approach to achieving network adequacy without this information being made public.

Appendix 3: Additional Comments

California Timely Access Reporting Requirements

At the August 5 meeting of the network adequacy workgroup, one of the participants inquired about whether Maryland could adopt California's Timely Access Reporting Requirements as a methodology for calculating waiting times. Kaiser has experience with these requirements in California and does not believe that they provide an accurate way to measure appointment waiting times for carriers and between carriers. They also do not provide timely feedback to carriers about how the carrier needs to consider making improvements to their network. We would be happy to discuss our California experience with the MIA if that's of interest.

Incorporating Telehealth into the Standards

Kaiser Permanente recommends that the MIA consider adding a telehealth credit to the network adequacy standards, similar to what is included in the new CMS regulations. Under those regulations, organizations will receive a 10% credit towards the percentage of beneficiaries that reside within the required distance standards when they contract with certain telehealth providers. Such a change would reflect the growth of telehealth as a modality of healthcare, especially during the COVID-19 pandemic. This change would also more accurately reflect patients' access to care. We would be happy to discuss this or any other proposal to incorporate telehealth in the network adequacy regulations.