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Health & Services

The Honorable Mike Kreidler, Insurance Commissioner
Washington State Office of the Insurance Commissioner
P.O. Box 40258
Olympia, WA 98504-0255

ATTN: Jim Keogh

Dear Commissioner Kreidler:

Re: Provider Network Rule: Stakeholder Exposure Draft released October 17, 2014

On behalf of Providence Health & Services, I want to thank you for the opportunity to provide commentary on the Office of the Insurance Commissioner's (OIC) proposed rule regulating provider networks.

Providence Health & Services is a not-for-profit Catholic health care ministry committed to providing for the needs of the communities it serves – especially for those who are poor and vulnerable. Providence and its affiliates employ 73,000 people across five states – Washington, Oregon, Alaska, California and Montana – with a system office located in Renton, Washington.

In Washington State, Providence and its secular affiliates, including Swedish Health Services, comprise 15 hospitals, 268 physician clinics, senior services, supportive housing, hospice and home health programs, care centers and diverse community services. The combined health system is the largest health care provider in Washington and employs more than 32,000 people statewide. In 2013, Providence and Swedish provided $413 million in community benefit, including $118 million in free and discounted care* for Washingtonians who could not afford to pay. Together, we are working to improve quality, increase access and reduce the cost of care in all of the communities we serve.

We appreciate the opportunity to review the proposed draft before the OIC moves to formal rulemaking by issuing the CR-102. We are troubled, however, by the apparent timeline as outlined in the email distribution notice, as it appears to be rushed at best and is not conducive to the open and transparent rule making process that was promised to our organization in April of this year. We join the other stakeholders and members of the Forum and strongly urge that the OIC engage in a stakeholder process that is built upon open discussion among all interested parties, and specifically includes direct- in person, discussions with feedback from OIC staff. This very inclusive process that was the hallmark of many rulemaking efforts in the past, but has been missing recently.

The following represents our specific comments on the stakeholder draft. We will repeat some of the issues that we raised in our comment letter submitted in response to the CR-101 notice of rulemaking as we believe they are important and were apparently not considered or incorporated into the stakeholder draft.

1) We urge the OIC to review the previously adopted rule R 2013-22 and revise based on the lessons learned during the 2015 plan year filing process, and incorporate necessary changes to clarify the intent of the rule. The following language in italics are the suggestions included in our

August 22, 2014 letter in response to the CR-101. We repeat them in this letter as it is important to address the concerns now and not wait until the **2017 plan year** and any follow-up rulemaking. Waiting 2 full years to address the problem is far too long a period of time.

Rural access *– The adopted rule requires less stringent access in rural areas and would make it increasingly difficult for rural residents to obtain care. This creates consequences for more than just hospitals, because the related ancillary services, such as primary care, will also be negatively impacted.*

This will in turn, weaken rural health networks and put rural populations at risk. We believe the current and longstanding Medicaid contract requirements for 25 miles of 90 percent of enrollment in all areas of the state is a reasonable standard and suggest that be adopted for the sake of access and continuity.

Geographic maps *- Providence appreciates the need to gather data – but it must be the right data. We continue to believe that if geographic maps are required, they should only be used to illustrate the location and distribution of the categories of providers/facilities. Language related to this should be further clarified to state that just because the maps demonstrate that the network meets the minimum standards set forth in this section, it is does not in and of itself mean the network is adequate. The OIC should consult with health care delivery experts, and other state agencies to assure that staff understands the complexities of the delivery system and barriers to access that exist in Washington State.*

In the event you choose to adopt this rule, we again suggest that WAC 284-43-220(3)(e) be modified to read:

> *(e)* ***Geographic Network Reports.***
>
> *(i) The geographic mapping criteria outlined below are for illustration purposes only to demonstrate the location and distribution of the various provider and facility types. The metrics listed below are not minimum requirements for determining that network is adequate, but will be considered in conjunction with the standards set forth in WAC 284-43-200 and 284-43-222. One map for each of the following provider types must be submitted:*

In-network cost sharing for out of network providers (WAC 284-43-201(1)(b)(i) *This section must be corrected during this next round of rulemaking, otherwise patients that are referred to non-network providers as part of the Alternate Access Delivery process would be allowed in network deductible and co-insurance amounts, but could still be charged out-of-network co-insurance amounts.*

Tiered provider networks *Tiered network information needs to be carefully considered. Although it is recognized that issuers should develop tiered networks with full access to all of the essential health benefits in the lowest cost tier, we are concerned that the language in the rule will stifle innovation. As ACOs and other value-based networks develop over time; a balance needs to be struck between sufficient consumer protection and disclosure without jeopardizing innovation. We urge the Commissioner to work with a variety of organizations and state agencies over the interim to understand the work underway to develop ACOs and establish more appropriate guidelines.*

2) **WAC 284-43-2021)(f)** We are concerned about the requirements of WAC 284-43-202(f) requiring notification of the loss of 15 percent of providers who treat individuals with chronic conditions. It is not clear to us how an insurer would identify these providers.

   Finally, it appears that an alternate access delivery request is required to be submitted if and when any of the metrics in subsections "a" through "f' are met. We question whether the AADR should be required if the metric is met, but the network is otherwise adequate.

3) **WAC 284-43-202(2)** Dealing with actuarial projections of health care costs. We believe this provision while important, should be included in the various rules dealing with rate filings. This provision appears out-of-place and not within the scope of this particular section of the rule.

4) **WAC 284-43-202(4) &(5)** We note that the OIC uses the term "Direct Access" in this rule without any clear definition. Please clarify what this terms means as it triggers some reporting requirements and it is not understood.

5) **WAC 284-43-202(5)** Providence is concerned about this particular section for a number of reasons. First, it appears to require a health issuer to monitor a variety of processes and procedures that fall within the medical care and treatment of a patient and mandates that the issuer "act to assure continuity and coordination of care in a manner consistent with professionally recognized evidence –based standards of practice." We question whether any health issuer is able to perform this function without adding significant numbers of medical professionals to its staff, and whether this oversight is even appropriate if it interferes with the patient provider relationship. Further, we question how the OIC will be able to enforce this provision. We strongly urge this entire section be the topic of an in-depth stakeholder process, and that the OIC proceed cautiously before adopting such requirements.

6) **WAC 284-43-251(7)** This section requires that an issuer send notice of a termination within 15 days' of receipt of a notice of contract termination. Issuers frequently receive notices of termination from providers that never actually end in termination. This is a standard practice of providers to signal the desire to begin contract negotiations. We strongly urge that the OIC revisit this time frame and require notice only when it appears that termination of the provider contract is actually going to occur. Premature notice will only cause patient confusion and anxiety. A more reasonable time period would be 30 days' before the termination date, if it appears that the contract will actually terminate.

7) **WAC 284-43-310(1)** Providence notes that this section has been modified and as a hospital based provider of services, we urge that all sections clearly include facilities when appropriate. For example WAC 284-43-310(1)(c) adds new language regarding participation in the network. This language speaks only to providers and does not address facilities. Because RCW 48.43.005 and WAC 284-43-130 both provide separate and distinct definitions of providers and facilities, it is important to include both providers and facilities in the rule's sections.

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We would welcome the opportunity to discuss these comments with you in person. If you have questions, please contact Kristen Rogers at: Kristen.rogers@providence.org or (253) 341-7733.

Sincerely,

Joel Gilbertson
Senior Vice President
Providence Health & Services