NoHLA

Northwest Health Law Advocates

Delivered via Email

October 31, 2014

Jim Keogh
Rules Manager
Office of the Insurance Commissioner
Insurance Building, Capitol Campus
Olympia, WA 98504

Re: Comments on Stakeholder Exposure Draft Provider Network Rules, Part 2

Dear Mr. Keogh:

Northwest Health Law Advocates (NoHLA) appreciates the opportunity to submit comments on the OIC's Stakeholder Exposure Draft of the second round of its Provider Network Rules for managed care organizations in Washington State. NoHLA is a Seattle-based non-profit organization that promotes increased access to quality health care and basic health care rights and protections for all individuals. NoHLA is a leader in consumer advocacy on public managed care programs, such as Apple Health Managed Care and the proposed HealthPath Dual Eligible Capitated Demonstration program. We are providing comments on the OIC's proposed provider network rules to try to ensure that the unique needs of low-income individuals, persons with disabilities and/or limited English proficiency, persons with special health care needs, and other underserved consumers are addressed by the network adequacy rules in our state.

WAC 284-43-202 Maintenance of sufficient networks

Sec. 1 - This section sets out specified standards for health plans to monitor their provider networks, with identified trigger points for them to reporting changes in plan metrics to the OIC and submit an alternate access delivery request (AADR). As a general matter, we strongly approve of this approach. It would, however, be helpful to know from where the specific numeric reporting triggers specified in this section and its composite subsections were taken. As discussed below, some of these trigger points raise questions about whether they can adequately fulfill their apparent purposes. Detailing the reasons behind their initial choice might help to clarify the connection between the specific trigger metrics chosen and their ability to ensure that network holes are detected and addressed by issuers on a timely basis as they arise.

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Additionally, we appreciate that the rule establishes an issuer's duty to monitor its ability to deliver covered services through its provider network. It would be helpful, though, to state more clearly that issuers must not only monitor their bare ability to provide such services, but also their ability to provide them in a culturally competent and accessible manner. This could be achieved through the following language change:

> An issuer must monitor on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish health plan services to enrollees in a manner that is culturally competent and that is accessible to individuals with disabilities and/or who have a primary written or spoken language other than English.

Sec. 1(b) requires notification of the OIC of a "[t]ermination or reduction of a specific type of specialty provider on the American Board of Medical Specialists list of specialties, where there are fewer than two of the specialists in a service area".

As a primary matter, this rule would benefit from a clarification as to what "specialties" are intended to be encompassed in the "American Board of Medical Specialists[1] list of specialties" referred to here. The American Board of Medical Specialties lists approved general specialty and subspecialty certificates in which ABMS Member Boards can offer certification. It is not clear whether proposed WAC 284-43-202(1)(b) creates a reporting trigger when a network has fewer than two providers in with a particular "general certificate" of specialization within a given service area, or whether the reporting is required whenever there are fewer than two providers in a given service area with a particular ABMS-approved subspecialty certificate, or both. The former interpretation would be extremely problematic. For example, no general specialty certificates are offered for Cardiovascular disease, Endocrinology, Geriatric Medicine, Hematology, Hospice and Palliative Medicine, Infectious Disease, Medical Oncology, Nephrology, or Pulmonary Disease, which are all listed as certificated subspecialties that can fall within one or more generally certificated specialty (e.g., family medicine, internal medicine, and physical medicine and rehabilitation.)[2] If the rule only required a health plan to notify the OIC and a request an AADR when there is a dearth of generally certificated specialists, that could result in situations where only family medicine, internal medicine or physical medicine practitioners without any specialized cardiac training or experience will be available to an enrollee in a given service area to treat something as common as cardiac care. If health plans are required to report and request an AADR when the number of in-network specialists in any of a number of identified specialties falls

[1] We assume that the this provision was actually meant to refer to the American Board of Medical Specialties, not the American Board of Medical Specialists. *See* American Board of Medical Specialties website, http://www.abms.org/.

[2] *See* American Board of Medical Specialties, Specialty and Subspecialty Certificates, http://www.abms.org/member-boards/specialty-subspecialty-certificates/ (last viewed October 29, 2014).

below a specified level in a given service, the rule should make clear that the specialties in question are at least "the approved specialties and subspecialties in which American Board of Medical Specialty Member Boards can offer certification."

However, even with this change, the rule seems insufficient in its sweep to serve its intended purpose. This standard may be broad enough to guard against specialty access problems in relatively sparsely populated areas. However, it will clearly be insufficient to prevent or plug network holes in areas with a relatively large population. For example, it is hard to imagine that two local in-network cardiovascular disease specialists will be sufficient to meet the health needs of a large health plan's membership in a populous county (e.g., King, Pierce, Snohomish or Spokane County). Also, this trigger fails to account for differences in the relative frequency of need for care from different kinds of specialists. For example, there is probably a need in most counties for a higher number of physicians specializing in internal medicine or emergency medicine than in colon and rectal surgery (all generally certificated ABMS specialties). If a trigger of this sort is to be retained to ensure that health plans will be able to provide adequate access to specialty care throughout their service areas, the OIC should consider how to structure it in a way that is sensitive to the population size/density and relative need for the specialty in question in any given service area.

Sec. 1(d) requires notification of a reduction of 5% of PCPs with open panels in a service area. However, specific event or time is listed as the date from which such reductions are to be measured. We suggest that the start time (e.g., the initial approval date, the last annual approval, etc.) be stated explicitly. Moreover, regardless of the start date chosen, it is difficult to judge the utility of this particular standard without reference to the source of the specific percentage and baseline timeframe for measuring if changes to this metric have reached the trigger point. Certainly, we wish to ensure that health plan reports and act quickly to address significant reductions of the PCPs they make available to their enrollees. The question is why is a reduction in 5% over a certain period of time the level of change at which action should be required? We would appreciate if the OIC would share the source and supporting information for the choice of this trigger point.

Sec. 1(e) - This section requires notice for termination or expiration of a contract with a hospital or an associated medical group within a particular service area. We agree that notice of this material change to a network should trigger notice to the OIC. As such, we support this provision.

Sec. 1(f) – It is unclear what it means to be a "provider for a specific chronic condition or disease." Certain conditions may be treated at least on a routine basis by a general practitioner or family practitioner, as well as by a specialist who focuses on treating the condition or organ system it afflicts in that patient. Also, for some conditions, multiple provider types may be able to deliver at least part of the range of appropriate treatments. For example, psychologists, licensed social workers, psychiatrists, and certified mental health counselors may all deliver some

of the same types of mental health services, although a provider with prescribing privileges may be required for other types of care needed by patients with a mental health condition (e.g., initiating, monitoring and changing pharmacotherapy). If a trigger point of this sort is to be retained, the rule should be tweaked to clarify who counts as a "provider for a specific chronic condition or disease."

Part of defining who counts as a provider of this type may also involve stating more clearly what level of specificity the rule requires to identify a "specific chronic condition or disease." The term "cancer," for example, includes a host of conditions. Consequently, we expect that "cancer" would not be specific enough to constitute a "specific chronic condition or disease" under the rule. Otherwise, no reporting or AADR request would be triggered if a plan included a large number of oncologists who specialize in the treatment of some cancers in a health plan's network, even though it failed to include a sufficient number and variety of oncology subspecialists to adequately treat other types of cancer. However, even if "cancer," is not specific enough, it is unclear whether cancers of the hematopoietic and lymphoid tissues, lymphoma, non-Hodgkin lymphoma, or follicular lymphoma (a category of non-Hodgkin lymphoma), for example, would satisfy the level of specificity of chronic condition or disease anticipated by the proposed rule.

Additionally, by only applying the trigger to a reduction in "provider[s] for a specific chronic condition or disease," when at least 5% of enrollees have the condition, the rule fails to adequately account for the need for subspecialists, such as pediatric subspecialists, within a particular specialty, to treat certain enrollee subpopulations. A loss of all pediatric subspecialists of a given type in a plan's network might not trigger notification under the rule, unless they treat a qualifying specific chronic condition or disease only contracted by children. Even then, if the condition is only or very predominately found in children, it will be more difficult for the condition to meet the rules' second condition for notification – that 5% of the plan's <u>total enrollee population</u> had the condition in the previous 60 days.

Given the complexity in applying the rule as written, we would appreciate if the OIC would share the reasoning behind its currently proposed language and consider whether some other metrics or some clarification of this rule would appropriately trigger notification of the OIC and when there are non-negligible changes in a given specialty's representation in each of a plan's service areas that run a significant risk of negatively impacting enrollee access to specialty care.

Sec. 3 – We strongly approve of the rule's explicit exclusion of closed practices from the determinations of whether a plan's network fulfills network adequacy standards for some purposes (i.e., "to justify adequacy for anticipated enrollment growth"). It is, however, critical that this requirement be extended to prevent closed practices from being counted when determining whether a plan fulfills network adequacy requirements for <u>any</u> purposes (not just for anticipated growth). It is of little use to current enrollees who wish to change providers, or whose providers leave the provider network, that the issuer has plans to enroll sufficient "open panel"

providers to address future enrollment expansion. Moreover, while geo-mapping can fairly easily cross-reference the locations of existing enrollees with provider locations, it is less obvious how plans will determine the sufficiency of provider networks to accommodate enrollment expansions without being able to predict the locations of future enrollees. Excluding closed panel providers only from determinations of compliance with provider network adequacy standards related to enrollment changes also creates an incentive for plans to underestimate enrollment expansion so as not to subject themselves to the full level of network adequacy requirements that they should actually be prepared to meet. As a result, closed panel providers should not be considered when determining whether an issuer meets network adequacy standards for any purposes.

Sec. 4 – This is a good requirement, but narrower than it needs to or should be. The mandate that issuers must have a sufficient number and type of providers in its network to meet new and current enrollees' needs should not be restricted to providers "for whom direct access is required." Whether or not an issuer requires enrollees' to obtain a referral to access a particular provider type's services, the issuer must ensure that there is a sufficient number of each such provider type to make their services accessible to enrollees.

Sec. 5 – We support the inclusion of requirements that health plans demonstrate that they have adopted professionally recognized procedures to monitor and ensure continuity and coordination of care for their enrollees. The rule's likely effectiveness at ensuring that enrollees receive adequate continuity and coordination of care, particularly during care transitions, would be clarified with some feedback regarding what "professional recognized evidence-based standards of practice" are likely satisfy the rule's requirements. Including in the rule a non-exclusive list of examples of such standards and/or the organizations that promote them could help plans and regulators ensure compliance.

The rule would also benefit from a clarification of its "baseline" standard for compliance. This subsection lays out two independent requirements for health plans, that they - 1) monitor the continuity and coordination of care their enrollees receive; and 2) ensure continuity and coordination of care for their enrollees. However, the rule then appears to elide those two requirements in stating that "[t]he baseline for such coordination [of care] is monitoring [certain enumerated practices] as often as is necessary, but not less than once a year". While monitoring may help ensure that adequate care coordination takes place, it does not alone constitute or ensure such coordination. If anything, the relationship between monitoring and ensuring adequate care coordination is exactly the reverse. Monitoring care coordination is a necessary but not sufficient condition for ensuring that adequate care coordination actually takes place. The previous draft of this rule issued in December, 2013 appeared to acknowledge this, listing "monitoring as often as is necessary, but not less than once a year, the level of collaboration between medical and mental health providers" as one of several enumerated practices that constituted the "baseline for such coordination [of care]." Proposed

Sec. 284-43-202(6). We suggest that the current draft of the rule be clarified to make clear that any baseline standard for health plans to meet to demonstrate that they are ensuring care coordination for their enrollees is not fulfilled simply by the plans monitoring their employees' and providers' care coordination activities (or lack thereof). Instead, the rule must mandate that health plans fulfill substantive requirements for the delivery of care coordination services either by their employees or their providers.

Additionally, to the extent that plans must establish minimum levels of monitoring of their care coordination practices, that monitoring should be conducted more frequently than annually. During an initial period in which a plan is offered or directly following a significant change to a plan's care coordination practices, monthly monitoring should be required; otherwise, monitoring should occur no less frequently than on a quarterly basis.

WAC 284-43-225 Issuer record keeping

Sec. 2 – Issuers should not only identify and keep records of outright denials of services, but also plan actions that result in a reduction of the amount, duration or scope of services provided to enrollees. Additionally, they should be required to identify and record the reasons for these denials, terminations and reductions of services using a standardized set of reason codes.

WAC 284-43-251 Enrollees' access to providers

This section should be expanded to clarify that individuals with chronic conditions may select as their primary care provider a specialist in the plan's network who is currently treating their chronic condition or who is accepting new patients with that condition. This will facilitate timely, appropriate and well-coordinated care for patients with chronic conditions. The alternative – requiring patients with chronic conditions to see two providers (a PCP and specialist) regularly, even when the care the patient requires can sometimes be more easily and efficiently be managed by the specialist alone – will increase the number of duplicative appointments for such patients and result in disjoint care for individuals with serious health needs. We suggest that such a provision be added either at the end of Sec. 1 of this rule, which discusses access to PCPs, or to renumbered Sec. 3, which discusses the requirements that individuals with chronic conditions be allowed to have direct access to specialists when they have standing referrals to them.

Sec. 1(b), 2(b) – We appreciate that the rules would properly require health plans to ensure <u>at all times</u> that there are sufficient open-panel PCPs and pediatricians in the plan's network to accommodate both new enrollees *and* allow existing enrollees to change providers. It is, however, unclear why the proposed rule limits these guarantees to PCPs and pediatricians, or why the rule does not further specify that plans must ensure that there not only be a sufficient gross total of the specified provider types in any given area, but that there also be a sufficient geographic distribution of these providers and sufficient numbers of them that provide culturally competent care and that are accessible to enrollees with a variety of

language barriers and disabilities. Health plans are already generally required by rule to maintain networks that include a sufficient numbers of geographically dispersed providers of a variety of provider types and that provide accessible care. These requirements should be made more explicit in this rule. Otherwise, the rule's focus on specifying health plan's duties to fulfill these requirements only for PCPs and pediatricians could be read as undermining the broader requirements to maintain accessible networks found elsewhere in the WAC.

WAC 284-43-310 Selection of participating providers – credentialing and unfair discrimination

Sec. 1(c) We appreciate the addition of a provision that explicitly bars discrimination against providers based on the providers' type or category (if the provider is acting with the scope of their license), when a plan is deciding whether to include a provider in its network. We urge you, however, to change the rule so that it bars discrimination of this type under any circumstances, and not only when discrimination is based solely on the provider's type or category. Discrimination based on provider type is properly called out by the rule as an improper basis on which to reject a provider from inclusion in a health plan's network, as it can mask the plan's actual intent either to: a) reduce/avoid covering particular costly treatments frequently offered by the provider type in question or to reduce; or, b) reduce or avoid covering patients with conditions requiring costly care who are frequently seen by such providers. This remains true, though, whether or not there are independent reasons for rejecting a particular provider's application to join a health plan's network. If there are independent and sufficient legitimate grounds for rejecting a provider's application for inclusion in a network, the provider may be properly be excluded by the health plan. But the provider's category or type should play no role in this calculation, so long as the provider is seeking inclusion in the network to offer health care services within the scope of her or his practice.

Additionally, as some provider types are not required by law to have a license to deliver health care services, the term "the scope of their license" should be substituted with the term "the lawful scope of their practice."

WAC 284-43-320 - Provider contracts standards – hold harmless provisions

Sec. 6(d) – It is unclear why this subjection, which would require health plans to give providers and facilities "full access to the coverage and service terms of the applicable health plan for an enrolled patient", is being proposed for addition to the rule. It is likely appropriate for a plan to disclose to a provider any terms of a patient's coverage that are necessary to allow the provider to obtain payment under the health plan for covered services delivered to the patient or to enable the provider to inform the patient, when asked, about the financial implications of a patient's decision to pursue a given course of treatment. However, it is not clear why all of a patient's providers necessarily require or should be given access to all the terms of their patients' health plans without articulating any particular need for them. We would appreciate if you would explain the aim of this section and reconsider whether it need be cast so broadly to achieve that purpose.

WAC 284-43-330 Participating provider – filing and approval
Sec. 6 – We appreciate the OIC's inclusion of provisions that would require health plans to submit and call out to the regulator unusual reimbursement agreements with providers, and for the OIC to review such agreements to ensure that they do not result in unlawful discrimination or encourage selection against such plans by individuals with serious health care needs or disabilities. This provision should be strengthened in at least two ways.

First, reimbursement provisions tied to health outcomes, the utilization of specific services and patient volume all run the risk of creating incentives for providers to tailor patient care in a manner that is unrelated either to a patient's preferences or to the most clinically appropriate care for the person in question. For example, tying compensation of providers to their patients' health outcomes, if not structured carefully, can create incentives to providers to avoid taking or to stop serving patients with serious or chronic conditions that are unlikely to abate or improve soon. Tying compensation to patient volume can create incentives to providers to minimize patient care time, or to shift care to lower-level providers, rather than provide the time to each patient from the level of provider that is most appropriate to serving that patient's health care needs. And, tying reimbursement to the provider's delivery of certain health care service can create an obvious incentive for the provider to favor the use or prescription of those particular services, irrespective of the services' clinical merits compared with those of other appropriate treatments. Some such compensation agreements (e.g., certain types of outcome-based provider compensation that doesn't penalize serving high-needs patients), if structured properly, may prove promising at increasing good health outcomes without an attendant increase in health care costs. But, at the very least, health plans should be required to inform their enrollees and providers should (and should be required to) inform patients whenever the plans' have compensation agreements with the patients' providers that create incentives for delivering patient care that may be at odds with the patients' best interests or at least create the appearance of a possible conflict of interest. Pay for play agreements, under which providers receive increased compensation from health plans for utilizing or prescribing certain services should likely be banned altogether. If the Commissioner is not inclined to prohibit them completely at this time, he should clearly articulate the benefit that he anticipates they will confer on consumers, how this benefit is outweighed by the conflict of interest they create for consumers' health care providers, and how that conflict will be adequately addressed through mechanisms other than a ban.

Second, the Commissioner's duties to review any such compensation agreements to prevent unlawful discrimination should explicitly include a duty, similar to that found in 45 C.F.R. 156.225(b), to identify and reject health plan compensation agreements "that will have the effect of discouraging the enrollment of individuals with significant health needs" in the plan(s) in question.

Thank you for giving us this opportunity to comment on the stakeholder exposure draft or the second round of the Commissioner's provider network rules. We look forward to continuing to work with other stakeholders and the OIC to develop a system that ensures enrollees timely and affordable access to all services covered by their health plans. If you have any questions about this, please contact Daniel Gross at 206-325-6464 or at Daniel@nohla.org.

Very truly yours,

Daniel Gross
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