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March 20th, 2015

Washington State Office of the Insurance Commissioner
P.O. Box 40258
Olympia, WA 98504-0255
Via email rulescoordinator@oic.wa.gov

Dear Commissioner Kreidler:

Re: March 3, 2015 Exposure Draft of Network Access Rule - R 2014-08

On behalf of Providence Health & Services, I want to thank you for the opportunity to provide comments on the Office of the Insurance Commissioner's (OIC) latest exposure draft rule regarding network access. Providence appreciates the time and effort your agency has contributed to this rule exposure draft regarding network adequacy, and your agency's commitment to soliciting stakeholder input throughout this process. Upon reviewing the proposed rules, we respectfully submit the following comments outlining concerns shared by Providence Health & Services including its affiliates Swedish Health Services, Pacific Medical Centers (PacMed), and Kadlec, Providence Health Plan (a registered health care service contractor) and the Providence-Swedish Health Alliance as our Accountable Care Organization.

Although we continue to express concerns about the scope of the Network Rule adopted last April for the 2015 Plan year, and are disappointed that our previous request that some sections be revisited during this rulemaking activity was not addressed, we will not repeat our requests in this letter. We encourage the OIC to consider our previously submitted comments as it addresses potential changes to this particular draft.

Maintenance of sufficient provider networks - WAC 284-43-202 (2)

Providence Health Plan understands the underlying reasons for notification of provider losses due to contract termination that would significantly impact the networks ability to meet standards set forth in WAC 284-43-200, however we strongly believe that the administrative burden placed on issuers in general and Providence Health Plan is excessive. Specifically:

1. The timelines proposed in this section are entirely too short for issuers to implement, and may not provide the issuer with enough time to contact the provider and analyze the remaining network to determine the impact and whether an Alternative Access Delivery Request (AADR) is necessary, and
2. The triggers for reporting outlined in this section would generate an inordinate amount of unnecessary documentation that would flood the OIC and make poor use of issuer and OIC resources to regulate this issue overall.

In order to balance the need for notification with the desire to make sure that notification makes effective use of resources at the OIC, we recommend that the OIC work with the Association of Washington Health Care Plans to come up with reasonable timelines for submission of an AADR. It is also important to note that the requirement that all potential contract terminations that may impact the ability of its network providers or facilities to deliver care, result in a required notification to the OIC may be unreasonable, given that it is a common business practice for providers including our own Providence health care providers to send contract termination notices to issuers as a way to start contract negotiations.

Because the vast majority of these provider or facility -initiated termination notices and subsequent negotiations do not result in actual terminations, this would have a huge increase in workload that would later be rendered wholly unnecessary. We strongly urge the OIC to remove the requirement to for issuers to notify the OIC of every single provider-initiated termination notice in favor of policies that would instead hold issuers accountable for notifying the OIC of an actual disruption in provider networks.

Maintenance of sufficient provider networks -WAC 284-43-202(3) (a)-(f):

We agree on the importance of notifying the OIC of significant changes to networks that would lead to disruptions in a patient's ability to access appropriate, quality care through specific "triggers" that proxy significant disruptions. However, it is important that we land on the right triggers that would result in meaningful notice to the OIC. Two especially problematic "triggers" caught our attention here:

- For example, according to the proposed trigger in part (b), a statewide plan may have their network decreased to only three of a particular type of specialist in the state and they would not be required to report under WAC 284-43-202(3)(b). Instead, we recommend that the OIC make determinations based on a location other than service area, such as a group of contiguous counties with normal health care practice or delivery area referral patterns or their rating area established in rule**.**
- In part (f), the requirement to notify the OIC of a 15% reduction in the number of providers or facilities for a specific chronic disease that affects more than five percent of an issuer's enrollees brings up a number of questions for us as we think about how this could be implemented.
    1. How would an issuer identify these providers? In particular, many chronic conditions are treated by both primary care physicians and specialists. A patient being treated for diabetes could be treated by a primary care physician, cardiologist, endocrinologist, nephrologist, ophthalmologist and a whole host of other provides depending upon the patient's complications.
    2. The way the rule is written does not necessarily ensure adequate access for patients experiencing specific conditions. How would providers treating specific chronic conditions be weighted to ensure adequate access for the most prevalent conditions?
    3. How would this rule support the management of chronic conditions at a PCP level rather than a t a specialist level? Medical evidence supports that many chronic conditions, when caught early, can be managed more effectively at the PCP level, with patients demonstrating better overall health outcomes at a cheaper cost. Yet this rule does not acknowledge what percent of chronic conditions could or should be managed at a PCP level in order to incentivize more effective management of care. Careful attention need

to be paid to these triggers in order to ensure that the rulemaking process is acknowledging where health care needs to go in order to pursue innovations that lead to better health outcomes and lower costs.

Maintenance of sufficient provider networks WAC 284-43-202 (3) (g):

We agree that any sort of notice to the OIC of a potential disruption should include an issuers preliminary notice of whether an AADR will need to be submitted, but again we believe that the timelines for developing the actual AADR are too short, especially if additional negotiations with alternate providers are required to fill the void of the terminating provider or facility.

Maintenance of sufficient provider networks WAC 284-43-202 (5) (d):

We are particularly concerned about this section for a number of reasons. We strongly believe that this section misplaces accountability for the medical delivery of care on the issuer, rather than the provider of care, and would be an unprecedented intrusion of the issuer into patient care, leading to burdensome and costly processes and, ultimately, to decreased access to affordable care for Washington's citizens.

The proposed rules in this section would necessitate the issuer to gain far more direct access to the patient's medical records and insert itself in to the medical management of the patient. Providers and facilities may be required to submit more reports or data to the issuer to support the monitoring of the network's performance, thereby increasing the administrative burden on the provider/facility, and leading to increased costs of care. This is of particular concern to our providers, as this would be an unbelievable burden on caregivers who contract with multiple issuers, which many of them do.

In addition, our Accountable Care Organizations, Providence-Swedish Health Alliance and CareUnity, are actively transforming health care delivery and financing toward a more value-driven platform by accepting accountability for quality of care, patient experience, and total cost or other cost sharing arrangements. Through this section's intrusion of the insurer in to patient care, we are concerned that the issuer may introduce additional administrative burdens and potentially inefficient or redundant health care services, reducing the total value of efficient, high quality health care in Washington communities.

Provider contracts-Standards-hold harmless provisions WAC 284-43-320 (3):

We recommend that the OIC clarify whether existing contracts need to be amended to modify any previously approved hold-harmless language if it was a "variation approved by the Commissioner." The current proposed rule may open contracts to renegotiation and significant administrative costs for both issuers and providers/facilities. Although we prefer that this change not be made unless the Commissioner can demonstrate consumer harm, at a minimum we request that the OIC amend this rule to specify that the revised hold-harmless language will apply to new contracts entered into on or after the effective date of the rule, or when the existing provider contracts renew or are otherwise amended.

Provider contracts-Standards-hold harmless provisions WAC 284-43-320 (6):

The current proposed timelines within sections (a) and (b) need to be clarified to avoid the unintended consequence of providers being forced to accept changes in administrative policies or procedures impacting compensation for a period of time if the 60-day notice periods do not line up correctly. Part

(b) in particular creates a potential timing issue between the receipt of the proposed change and the right for the provider/facility to exercise its right to terminate the contract because the provision is made subject to the 60 days' notice of subsection 9 of this subsection.

Participating provider-Filing and approval (WAC 284-43-330):

We request a clarification of how the modifications to a previously approved template are to be filed and subsequently issued to the provider following approval. The proposed rule reads as if the red-line version of the contract is the required version to be filed with the department and issued to the provider. We assume the intent of this provision is for the OIC to receive the provider template in final form as the filing; the redline form as a supplemental document and once the filing is approved the issuer will receive the contract in final (not redline) format.

Participating provider-Filing and approval WAC 284-43-330 (6):

As a health care organization on the forefront of innovative care and payment models, Providence supports efforts to move the health care delivery system towards reimbursement methodologies that reward improved health outcomes. And as part of our mission to provide care for the most vulnerable, we are in agreement that health care access should not discriminate against patients with serious or complex medical conditions. We also believe that it will not be possible for entities to pursue innovative payment structures that implement discriminatory practices in order to achieve lower costs and to achieve improved health care outcomes at the same time. The most effective practices will be rewarded by reimbursement methodologies that hold the provider accountable for BOTH health care outcomes AND total cost of care.

We are concerned, however, that this section as written provides no meaningful measures on how the Commissioner may find certain reimbursement methodologies to be discriminatory or promote rationing of care. As such, it may serve to stifle innovation or create unreasonable barriers to the development of appropriate reimbursement methodologies that reward providers based on health outcomes. So, while we understand the OIC's need to protect consumers against discriminatory practices that restrict their access to appropriate care, we also urge the OIC to consider how we can work together to ensure innovative payment models are incentivized and not penalized for focusing on providing patients access to the right care at the right time based upon medical evidence.

Again, we thank you for the opportunity to provide our comments on this proposal. We believe that network adequacy regulations that are able to strike the delicate balance between protecting patient access to care with the need to incentivize competition and innovation among providers will be absolutely crucial to true health care reform. We look forward to your response and any opportunity to work with OIC staff on subsequent exposure drafts and draft rules. For more information, please contact Lauren Platt, state advocacy program manager, at (425) 525-5734 or via e-mail at lauren.platt@providence.org.

Sincerely,

Joseph M. Gifford, MD
Chief Executive, ACO
Providence Health & Services