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March 18, 2015

The Honorable Mike Kreidler, Commissioner
Washington State Office of the Insurance Commissioner
P.O. Box 40255
Olympia, WA 98504-0255

ATTN: Jim Freeburg

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

Dear Commissioner Kreidler:

On behalf of the Washington State Medical Association and its physician and physician assistant members, we wish to thank you for the opportunity to submit comments on the most recent exposure draft. In particular, we wish to thank you for the steps you have taken to improve the stakeholder process for this rulemaking effort.

In general, we support provisions in this rule that emphasize that networks may not be created in a manner that discriminates against patients based on their health status. Issuers should be required to develop networks that are fully capable of meeting the needs of the defined network and should not discourage enrollment by individuals with complex or chronic medical conditions because of the lack of in-network specialty providers and facilities.

The WSMA is concerned, however, by some of the rule's provisions that may interfere with the clinical judgement of the physician in the diagnosis and treatment of his or her patient. The strict line of demarcation between the issuer as the payer of services and the physician in providing the medically appropriate services appears to be eroding, as we will discuss below.

Maintenance of Sufficient Provider Networks – WAC 284-43-202

The WSMA supports the concept of the issuer actively monitoring the status of the network and notifying the Office of the Insurance Commissioner when there is the potential that the network will no longer meet the standards of WAC 284-43-202. Our members and their patients are often negatively impacted when there is network disruption, such as a loss of a hospital or a multi-specialty group to which our members' patients are referred. The ripple effect of a network that is no longer adequate can be far reaching in its impact on the timely provision of medically needed care.

We believe that it is important that the OIC be notified when there is a likelihood of a network disruption that is material to the delivery of health care services. While some of the triggers under WAC 284-43-202(3) make sense – such as the loss of a hospital or a hospital-based medical group – others require refinement.

Specifically, we urge the OIC to evaluate how the demand for specialty services is monitored. For example, if the number of a particular category of specialists (within a defined service area and who are actively caring for patients) is approaching a critical point at risk of falling below a predetermined threshold, that decline could result in a network that is significantly inadequate.

Consideration also should be given to establishing the thresholds for the minimum numbers of a specialist by type. For example, having two cardiologists in a service area may be inadequate, while having two pediatric neurosurgeons may be adequate.

Also, consideration should be given to redefining the geographic area from the current "service area" to a more relevant and smaller unit of measure such as a county.

Monitoring of "certain network models" WAC 284-43-202(5) (d)

This subsection that appears to be directed to unique types of networks, such as medical homes, is particularly concerning. As drafted, some of the standards require the issuer to evaluate whether the physician is utilizing "appropriate diagnosis, treatment and referrals." In addition it appears that the "…issuer must perform continuity and coordination of care in a manner consistent with professionally recognized evidence-based standards of practice." As written, this provision appears to require that the issuer conduct the actual performance of care coordination, rather than to monitor the performance of such activities by the network providers.

As drafted, it appears that the OIC expects the issuer would impose an unprecedented and unacceptable level of oversight on the physician and directly interfere with the patient/provider relationship and is an overreach into the "practice of medicine." We recommend that the OIC conduct further discussions with the physician practice community to gain a better understanding of the types of care innovations that are currently in play, and then use those findings to significantly revise this section and thereby more clearly differentiate between the role of the issuer/payer and the role of the physician.

Please also consider that the continuing evolution and innovations in providing health care services necessitates that these WAC provisions mesh with, and not disrupt, those constructive innovations. Also, the lack of specificity in defining the types of "certain network models" that would be affected by these WAC provisions needs to be addressed through more concrete definitions.

Enrollee's Access to Providers & Standing Referrals WAC 284-43-251

The WSMA supports the revision to this section that requires a sufficient number of primary care providers and pediatricians. Consideration should be given to including a subsection referencing an adequate number of specialists and sub-specialists as well.

In addition, the WSMA supports retaining the requirement that issuers accept standing referrals for patients with complex medical and mental health or substance use disorders in the rule (WAC 284-43-251(d)).

Enrollee's Written Notice of Termination WAC 284-43-251(7) & WAC 284-43-320(10)

The WSMA supports the 30-day advance notice to patients of the termination of providers or facilities from an issuer's network. We also request that the notice be provided to the remaining network providers that may have admitting privileges to the terminating facility, or routinely refer patients to a specialty group. The loss

of facility or multi-specialty group may have a significant impact on existing traditional referral patterns for the remaining in-network providers.

Provider Contracts – Standard Hold Harmless WAC 284-43-320

The WSMA does not believe the change to WAC 284-43-320(3) is necessary; we believe that it will have a significant impact on our members' administrative staff to deal with contract amendments. Therefore we request that if adopted that it be required only for contracts entered into or modified on or after the effective date of the rule.

The WSMA supports the changes made to WAC 284-43-320(6) including the providing of the documents electronically.

We also support the requirement that issuers provide at least 60-days' notice of changes to the policies and procedures that impact compensation. It is important, however, that adequate time be given to the providers to review the changes once notice is received in order to determine whether or not to accept the change or terminate the contract. The reference to subsection nine's 60-day notice of termination to the issuer does not give the provider enough time to evaluate the proposed change. At a minimum, issuers should be prohibited from implementing the change if the provider sends a notice of termination.

Reimbursement Agreements Based on Health Outcomes or Utilization of Specific Services WAC 284-43-330(6)

The WSMA supports the public policy position that recognizes that the reimbursement methodology should not result in discrimination based on health status or "rationing" of health care services. We request that the Commissioner provide specific examples of how this determination is to be made.

We welcome the opportunity to further discuss our points.

Sincerely,

Kathryn Kolan

Kathryn Kolan, JD
Director of Legislative and Regulatory Affairs

cc: Jennifer Hanscom, Executive Director/CEO
WSMA Executive Committee