Providence Health & Services
1801 Lind Avenue SW #9016
Renton, WA 98057
www.providence.org

July 21st, 2015

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

Attn: Jim Freeburg

Dear Commissioner Kreidler:

Re: Network Access Rule: CR-102 released June 16th, 2015

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) final draft rule regarding network access. Providence appreciates the time and effort your agency has contributed to this rulemaking process, and your agency's recent commitment to soliciting stakeholder input on future rulemaking processes.

Network access rules which are able to balance the need for consumer protection while allowing sufficient room for innovation are an important foundational element for true health care reform. 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 (ACO). As a system, Providence Health & Services encompasses 15 hospitals, 268 physician clinics, senior services, supportive housing, hospice and home health programs, care centers and diverse community services in Washington state, and employs more than 32,000 people statewide. We hope these comments will be considered in future discussions, as we work to implement the current rules and continue to move health care transformation efforts forward as a state.

Throughout this rulemaking process, we have continued to express our 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. Providence continues to believe that the regulations adopted on April 25, 2014 (R 2013-22) will seriously impede access for patients and stifle the burgeoning development of innovative integrated delivery networks which focus on coordinating care and improving health outcomes across Washington. Since the CR-101 Preproposal was drafted in a manner that could permit refinement and clarification of the previous network adequacy regulations, we had hoped that the OIC would consider the feedback they have heard from other stakeholders which have echoed several strong concerns, which are repeated at the end of this letter. However, it is clear that this feedback was not considered in the current rule. Therefore, we will repeat some of the issues that we raised in our comment letters previously submitted in response to the CR-101, October 15th, 2014 exposure draft, and March 3rd, 2015 exposure draft, as we believe they are

important to consider in future rulemaking and were not considered or incorporated into the stakeholder drafts.

Specific concerns with the final rule language included in this CR-102 are as follows:

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.

And as stated in our comment letter submitted on August 22nd, 2014, it would be helpful to have special notification requirements for “material providers” in this section as well. These providers and facilities are significant in terms of patient volume and services rendered. These are the types of providers and facilities including multi-specialty clinics and facilities that are often the foundation of a network in a geographical area, and the loss of its participation would cause significant patient disruption and lack of access. The OIC could require issuers to provide the OIC with a notification of a pending notice of termination of a “material provider” *before* the termination occurs. Additionally, it would be helpful if issuers had to also propose an action plan to address the loss of the material provider.

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(4) & (5): We note that the OIC uses the term "Direct Access" in this rule without any clear definition. In implementation, this is likely to cause confusion. In the future, we urge the OIC to clarify what this terms means as it triggers some reporting requirements and it is not understood.

Maintenance of sufficient provider networks - WAC 284-43-202 (5) (d): As previously stated, 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.

Enrollee Access to Providers - WAC 284-43-251: Providence urges the Commissioner to consider in future rulemaking careful review of this section so that it addresses both the more traditional participating provider networks as well as the integrated delivery networks – such as Accountable Care Organizations (ACOs). We have advocated that the rule contain a definition to clearly define and permit the integrated delivery networks and provide clear guidelines of how these networks provide access to participating providers that are not available for services within the integrated network. These would be highly specialized and unique services that while covered services would not necessarily be available within the integrated network such as transplantation and trauma care.

We strongly encourage the OIC to engage stakeholders in future discussions related to how as a state, we can balance the need for consumer protection without stifling competition. Within this conversation, we strongly urge the Commissioner to consider potential future requirements that participating provider networks provide access to the providers and facilities necessary to render all of the Essential Health Benefits – including all levels of primary and specialty care. These services should be available in network in order to meet state and federal law.

Our organization has been engaged in some of the very early work to bring together an ACO network in Washington and we hope you will allow us to share our experiences through a robust stakeholder process in the future to discuss these issues.

Enrollee Access to Providers - WAC 284-43-251(7): This section requires that an issuer send notice of a termination within 30 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. While PHS appreciates the change in the timeframe from the originally-proposed 15 days to 30 days, the current language does not address the issue previously stated in our comments regarding the frequency with which such notification is an unnecessary response to common business practices that often do not yield changes in providers. We are concerned that the rules as written would lead to premature notice, which will only cause patient confusion and anxiety. Instead, we had urged that the OIC require notice only when it appears that termination of the provider contract is actually going to occur. We would be happy to work with the Commissioner to discuss how a probably termination can be identified in order to yield more accurate notification.

Provider and facility contracts with issuers - WAC 284-43-300: Providence requests language regarding referral and contracting requirements pertaining to how integrated delivery systems - such as ACOs - provide access to services that are not available in the integrated network such as highly specialized and unique services. We continue to advocate that regulations recognize the ACOs' unique nature and function as well as carefully construct language so as not to stifle innovation.

Provider contracts-Standards-hold harmless provisions - WAC 284-43-320 (3): As previously submitted, we continue to 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): Again, as previously submitted, the 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 had previously requested 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. It appears that no clarification was made in the CR-102 draft rule.

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 Health & Services 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 continue to be 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.
In addition to the specific comments listed above pertaining to the language included in the CR-102 final draft rule, in the future, Providence again requests that the OIC revisit the rules adopted on April 25, 2014 to effectively address the issues that we, the Washington State Hospital Association and others called out as problematic for consumers as well as providers. We appreciate the recent efforts of the OIC and its staff to hold an open stakeholder process on policy issues for potential consideration in future rulemaking activities, and we hope that by re-stating these previously-submitted comments on network access rules already adopted but not addressed in this phase II rulemaking process can add to this dialogue as we continue to move payment reform and innovative health care delivery models forward:

Rural access: The adopted rule requires less stringent access in rural areas and would make it increasingly difficult for rural residents to obtain care. As previously stated, 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 this 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.

We again suggest that WAC 284-43-220(3)(e) be modified to read:

> (e) **Geographic Network Reports.**
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> (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): We are concerned that implementation of this rule as-is will allow patients who are referred to non-network providers as part of the Alternate Access Delivery process in network deductible and co-payment amounts, to 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 current 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 coming year to understand the work underway to develop ACOs and establish more appropriate guidelines.

Open and Inclusive Rulemaking Process: The commitment to stakeholder discussions as demonstrated in the recent Health Policy Roundtable meeting hosted by Commissioner Kreidler on June 3rd, 2015 gives us much hope and enthusiasm for such stakeholder processes in the future, and we look forward to continue this work as it applies to specific rulemaking needs. We hope that there will be future opportunities for stakeholders and the OIC to come to the table in order to develop network access regulations that protect consumers, support providers and promote innovation for issuers and ACOs, and address implementation issues with the current rules.

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 rulemaking processes. 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