Washington
State
Hospital
Association

February 21, 2014

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

Submitted by e-mail 2/21/14

Dear Commissioner Kreidler:

Thank you for sharing the second stakeholder exposure draft of the network adequacy rules. We appreciate the opportunity to provide further comments, which are included in the attached document. We are continuing to review the rule and consult with our members and may have additional comments in the future. Our general comments are summarized below:

1. ***Washington residents should have access to care, regardless of whether they live in an urban or a rural area, assuming there are providers and facilities in their areas.*** Network rules should include minimum requirements for access to care, including hospital services, primary care, and specialty care. It is unclear to us how the standards apply since there is no minimum standard for acute care, although it is included as a provision in the mapping requirements. To identify the minimum requirements for access to acute care, the Office of the Insurance Commissioner (OIC) should look to existing standards, such as the Medicaid contract standard or the federal standard for Critical Access Hospital designation.

2. ***Exceptions to minimum standards should be limited.*** To accommodate situations in which an issuer cannot meet the rule's requirements, it makes sense to have a process to review an "alternate access delivery request," as allowed for in the rule. But there should be no automatic exemption, based on the population of the county, for complying with the access to care requirements of the rule. Allowing issuers in smaller counties to automatically avoid the requirements creates a disincentive for the issuer to negotiate reasonable contract terms with hospitals. This exemption is arbitrary, and it allows issuers to opt out of the requirements of the rules in almost half the counties in our state. Issuers should bear the burden of demonstrating a "reasonable basis" for requesting an alternative access provision.

3. ***The rules need to be clear.*** First, access standards should be clear and measurable. Mileage standards are much clearer and easier to measure than travel times. Second, the OIC should provide clarity on how it will determine whether the contracting process is fair and reasonable and, therefore, whether the issuer has submitted "clear and convincing evidence" of good faith efforts to contract. We have proposed language defining these terms in the attached document.

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4. ***Consumers need information that helps them make informed choices about insurance, based on provider and facility participation.*** There should be regular updates to the issuers' directories that clearly inform consumers about which providers and which facilities are part of an issuer's network. If an issuer is offering a tiered network structure, it should be clear which providers and facilities are part of each tier.

Thank you for your commitment to this effort. We look forward to continuing to work together to ensure reasonable access to care. If you have any questions about our suggestions, please contact Barbara Gorham at 206-216-2512 or BarbaraG@wsha.org.

Sincerely,

Claudia Sanders
Senior Vice President
Policy Development

Barbara Gorham
Policy Director, Access

Attachment

Outline of Issues in the Second OIC Stakeholder Draft of Network Adequacy Rules
Washington State Hospital Association – February 21, 2014
(Suggested changes appear in red.)

Significant Issues:

Alternate Access Delivery Requests: Our members are very concerned about the fact that the stakeholder draft includes an arbitrary exemption from the rule's access to care requirements: If the issuer is operating in a county with fewer than 50,000 people, it can automatically avoid the requirements of the rule and submit an alternate access delivery request to the Office of the Insurance Commissioner (OIC). Almost half of Washington's counties have fewer than 50,000 people, so this exemption will be applied very broadly. The rule already allows an issuer to propose an alternate access delivery request where it has a "reasonable basis" for doing so. A low-population county could, in fact, be a "reasonable basis" for making an alternate access delivery request, but the issuer should bear the burden of establishing why this fact makes it impossible to meet the requirements of the rule. Otherwise, there is no incentive on the part of the issuer to propose reasonable contract terms with providers and hospitals in smaller counties. ***We strongly urge you to delete from the draft the exemption from the rule's requirements for counties with fewer than 50,000 people, especially given that issuers are allowed to make an alternate request if they can articulate a "reasonable basis" for doing so.*** *(Page 22 of the redline draft).*

To compound this problem, there seems to be no criteria for what constitutes a minimally acceptable alternate access delivery request. The rule contains no guidelines, let alone standards, for what would be acceptable to the OIC. ***We request there be specific criteria in the rule with which to judge whether an alternate access delivery request is sufficient.*** *(Criteria should be inserted as a new subsection on page 23 of the redline draft between current subsections (3) and (4)).*

Standards for Access to Care: The second stakeholder draft reduces access to care in a number of ways. First and foremost, the requirement for access to acute care has gone from 30 miles in all areas of the state to 30 minutes in urban areas, and 60 minutes in rural areas. This change to a 60-minute standard for rural areas will significantly impede access to hospital services in many areas of our state. We see no reason why consumers in rural areas should have less access than those in urban areas, assuming there are providers available.

In addition, our members strongly prefer a distance standard over a time standard because it is clear and easy to measure. There is precedent in the law defining reasonable access to acute care, and the OIC should use one of these standards to identify the minimum requirements for access to acute care. The Medicaid contract requires one acute care hospital every 25 miles for 90 percent of enrollees in both urban and rural areas. Critical access hospital designation under federal rules requires that the hospital be at least 35 miles from another hospital. ***We request the OIC either adopt one of these standards for access to acute care, or go back to the 30-mile standard contained in the first stakeholder draft.*** *(Pages 38-39 of the redline draft).*

In addition, as we said in our comments to the previous draft, it is not clear why the acute care access requirement appears only in the "network reports" section of the rule, and not in the

"assessment of access" section. If the placement of the acute care access provision in the "network reports" section means the application will not be reviewed without the issuer demonstrating there is a hospital within the required distance contained in the rule, we would support keeping this provision in that section. *If not, we would request the acute care access provision be moved to the "assessment of access" section of the rule, with the changes requested above. (This would mean rewording this section and moving it from pages 38-39 of the redline draft to page 58.)*

We are also concerned about the change in the rule for access to primary care and mental health care. The previous draft required access within 30 minutes for enrollees in both urban and rural areas. The new draft requires access within 30 miles in urban areas and 60 miles in rural areas. Again, we see no reason for this distinction, assuming there are available providers. ***We would therefore request the primary care and mental health care access requirements be 30 miles in both urban and rural areas.*** *(Page 59 [primary care] and page 39 [mental health]).*

Finally, the rule states an issuer may also use providers and facilities in a neighboring service area to satisfy the access to care requirements for certain other types of facilities, including tertiary hospitals, pediatric community hospitals, specialty hospitals, neonatal intensive care units, and transplant centers of excellence, in the event there are none of these facilities in the service area. Although this language seems reasonable, the stakeholder draft fails to actually require the issuer to include these facilities in their network. ***We therefore request the regulations require issuers to include all of the types of facilities listed in subsection (3) on pages 60-61 in their networks. In addition, to ensure access to clinical trials, we request "cancer care hospitals" be changed to, "National Cancer Institute-designated comprehensive cancer care centers." We would also suggest the other specialty hospitals listed in subsection (3)(c) be more clearly defined in order to assure that the entire range of specialty services are available in-network.*** *(Pages 60-61 of the redline draft).*

Essential Community Providers: We appreciate that the rule now explicitly requires one essential community provider hospital per county. We also believe the rule should be clearer about the definition of Disproportionate Share Hospital (DSH). The rule includes DSH hospitals as essential community providers, but does not define what constitutes a DSH hospital. ***We would suggest that a DSH hospital be defined as any hospital that is receiving either Medicaid or Medicare DSH payments.*** *(Page 47 of the redline draft).*

Definition of "clear and convincing evidence of a good faith effort to contract" and "reasonable terms and conditions": In several places, the draft requires the issuer to present "clear and convincing evidence of a good faith effort to contract." We had requested this in our previous comments and we appreciate that the OIC included this language, but the term needs to be defined. The draft also refers to the "reasonable terms and conditions," which should also be defined. ***We request that the OIC include the following definitions of "clear and convincing evidence of a good faith effort to contract" and "reasonable terms and conditions."*** *(These should be inserted into the "definitions" section of the stakeholder draft.)*

"'Clear and convincing evidence of a good faith effort to contract' means the issuer has demonstrated that they have attempted to contract with the provider or facility at the same or reasonably proximate terms, payment structure, and rates structure as those it has negotiated

with other providers of the same provider or facility type in the county, or negotiated with other similar provider types in its network if no other similar provider or facility exists in the county."

"'Reasonable terms and conditions' means terms and conditions that are appropriate, given consideration of the specific provider or facility type, and the specific product being contracted."

Prior Authorization: The rule requires that issuers have processes in place to obtain prior authorization in a timely manner. ***At a minimum, the process should conform to the requirements of WAC 284-43-410, which spells out reasonable response times for prior authorization requests.*** *Although these regulations should already apply, it would be helpful for the network adequacy rules to include, or at least cross-reference, these provisions. (Insert on page 15 of the redline draft at the end of subsection (4)).*

Balance Billing: The rule says an issuer must make a good faith attempt to contract with provider groups in the ER if the hospital is included in the issuer's network. The Affordable Care Act requires insurers in this situation to pay their median negotiated rate, their standard rate, or the Medicare rate, whichever is greater. ***We would request, for clarity purposes, that the rule reflect federal law and explicitly contain this requirement.*** *(Insert on page 71 of the redline draft at the end of the new WAC 284-43-252.)*

Tiered Provider Networks: The rule requires all tiers of a tiered provider network to meet minimum network adequacy requirements. *We support this provision, but we believe the following language should be inserted:* ***"Issuers must not use tiered networks to discriminate or limit access to certain types of providers."*** *(Insert on page 57 of the redline draft as a new subsection (8)).*

Mental Health: Overall, we are very pleased with the OIC's inclusion of mental health providers in the Geographic Network Reports and Assessment of Access sections. *We believe the draft could be further improved in the following two ways:*

First, so that the map shows which providers have prescribing authority, we would suggest the following language be included on page 39, subsection (C) of the redline draft. *In the first sentence, after the word "must," insert,* "**show which providers have prescribing authority and** demonstrate that each enrollee in the service area . . . ."

Second, although the draft rule recognizes the need for enrollee access to substance use disorder treatment, the rule does not require the issuer to include chemical dependency treatment providers or facilities in their networks. *We suggest the following changes be made on page 62, subsection (7) of the redline draft:*

"At a minimum, an issuer's provider network must adequately provide for mental health and substance use disorder treatment, including behavioral health therapy. Adequate networks include crisis intervention and stabilization, psychiatric **and chemical dependency** inpatient hospital services, including voluntary psychiatric inpatient services, **detoxification services, chemical dependency outpatient treatment, chemical dependency programs,** and services from

licensed mental health and chemical dependency providers including, but not limited to, psychiatrists, psychologists, **and chemical dependency professionals** of sufficient number and type to provide for the coverage for the diagnosis and medically necessary treatment of conditions covered by the plan through providers acting within their scope of license and scope of competence established by education, training, and experience to diagnose and treat conditions found in the most recent version of the *Diagnostic and Statistical Manual of Medical Disorders* or other recognized diagnostic manual or standard."

Cost-sharing limits in alternate access delivery systems: All out-of-pocket cost limits should apply in an alternate access delivery system. *We would suggest the following change to page 20 (a)(i) of the redline draft:* "(i) Copayments and deductible, coinsurance, and out-of-pocket maximum requirements must apply to alternate network standards at the same level they are applied to in-network services." This makes it clear that all of the out-of-pocket costs must remain the same if an issuer is allowed to adopt an alternate network standard.

Access to Dialysis Services: The access to care requirements should include access to kidney dialysis. The Northwest Kidney Centers is submitting a number of recommendations to improve the draft rule in this respect.

Provider directories: *We have a few changes to suggest for the "provider directories" section. (Pages 26 and 27 of the redline draft).*

- First, throughout that section, "provider directories" should be changed to "**provider and facility directories**." Enrollees need to be able to see which facilities are included in-network in the issuer's online directory.
- Second, the rule should state that, "**where tiered networks are offered, the provider directory shall identify which providers and facilities are in which tiers**." (On page 27 of the redline draft, insert as a new subsection between (6) and (7)).
- Third, the directory should indicate which providers and facilities have the capacity to provide telemedicine, not those who are permitted to do so. The language would be clearer if "may" were deleted, so that the sentence reads. " . . . telemedicine services must be included and specifically described in each provider directory as to which provider **uses** them. (Subsection (5) of the provider directory section on page 27 of the redline draft).

Other Comments:

Geographic network reports: For clarity purposes, we suggest the mapping requirement identifying hospital and emergency services mention facilities as well as providers. *We suggest the following change:* "(A) Hospital and emergency services. Map must identify provider **and facility** locations, and demonstrate that each enrollee . . . ." (Page 38 of the redline draft).

Throughout the second stakeholder draft: *We request that, where reimbursement "rates" are discussed, the rule also mention* ***"reimbursement methods (such as percentage of bill charged, encounter rates, per-diems, and Diagnosis-Related Groups [DRG's])."*** *(Throughout the draft).*

Typographical error on page 12 of the redline draft, subsection (1): *The sentence should read,* "An issuer must demonstrate . . . services are readily available without **un**reasonable delay" (instead of "reasonable" delay).

For more information, please contact:
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