AAAHC

ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

January 27, 2022

Ms. Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9911-P
P.O. Box 8016
Baltimore, MD 21244-8016

Via Electronic Submission at *http://www.regulations.gov*

RE: CMS-9911-P
RIN 0938-AU65

Dear Administrator Brooks-LaSure,

The Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) appreciates the opportunity to submit comment to the Centers for Medicare & Medicaid Services (CMS) regarding the recently proposed Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023.

The AAAHC is a private and independent 501(c)(3) non-profit accreditation organization formed in 1979. Since its inception, AAAHC has promoted a voluntary, peer-based, and educational survey process to advance patient care. These values hold today, as embodied in our mission statement: *Improving health care quality through accreditation*. With more than 6,100 accredited organizations in a variety of ambulatory health care settings, AAAHC is a leader in developing Standards to advance and promote patient safety, quality care, and value for ambulatory health care through its accreditation programs, education, research, and other resources. Currently, more than 30 health plans are committed to excellence through AAAHC accreditation.

AAAHC is a recognized health plan accreditor through several federal and state agency regulatory agencies including the CMS Center for Consumer Information and Insurance Oversight (CCIIO) for Qualified Health Plans (QHPs), the U.S Office of Personnel Management (OPM) for Federal Employee Health Benefits plans (FEHBs), the Florida Agency for Health Care Administration (AHCA) for Health Maintenance Organizations (HMOs) and prepaid health clinics, and various state health insurance oversight agencies in Arizona, Georgia, Illinois, Kansas, Louisiana, Minnesota, Missouri, Nevada, New Mexico, Oklahoma, and Pennsylvania. AAAHC also provides accreditation services to the United States Coast Guard ambulatory health centers, Federally Qualified Health Centers that receive funds from the United States Health Resource and Services Administration (HRSA), Indian Health Services (IHS) funded health centers, and Correctional Healthcare units under the United States Federal Bureau of Prisons (BOP). Other AAAHC-Accredited Organizations include Ambulatory Surgical Centers, Community Health Centers, Indian Health Centers, Student Health Centers, Medical Group Practices, and Office-based Surgery Centers.

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The AAAHC founding principles are grounded in providing patients with options amongst health care services and the opportunity to choose the services that best fit their needs. Federal agency responsibilities set forth in Executive Order 14036: Promoting Competition in the American Economy establishes HHS must ensure every American's ability to choose health insurance plans that meet their needs through improved competition and consumer choice. All agencies must consider the influence their regulations, particularly licensing regulations, have upon industry competition and concentration. We are concerned that certain provisions within this proposed rule may be so burdensome to QHP issuers, resulting in the unintended consequence of eliminating options available to patients. The Affordable Care Act (ACA) and the Health Insurance Exchange were adopted to increase consumer choice and access to health care,[1] and we urge CMS to keep these goals in mind, especially as it calculates the burden[2] of this proposal. Each proposal compounds upon the next, creating a greater burden than perceived in a burden calculation that separately calculates the cost of individual proposals.

General Statement of Support

AAAHC would like to state its support of the CMS intention to:

- reinstate nondiscrimination requirements based on sexual orientation and gender identity,
- ensure benefits and coverage requirements are clinically based and reliant upon current and relevant evidence-based guidelines and recommendations,
- improve consumer ability to distinguish between coverage levels while ensuring sufficient issuer plan options,
- implement standardized display requirements,
- use lowest tier networks as the baseline for determinations of network adequacy,
- promote issuer accountability for enrollee health equity improvements through updated QIS requirements, and
- increase the number of contracted Essential Community Providers (ECPs).

Specific Feedback to ICRs

III. Provisions of the Proposed HHS Notice of Benefit and Payment Parameters for 2023

B. Part 147—Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

a. Past Due Premiums[3]

Request: CMS proposes to reinterpret the guaranteed availability requirements to require that insurers accept individuals and employers who apply for coverage where the enrollee owes past-due premiums, whether from the same issuer or another issuer in the same control group. Under the current interpretation, issuers who attribute a payment made for new coverage to past-due premiums owed within the prior 12-month period do not violate guaranteed availability requirements. CMS initially implemented this policy to address concerns that individuals would take unfair advantage of grace periods but is now reassessing the interpretation as a potential unnecessary barrier to health coverage access. Under the proposed interpretation, an issuer may not apply a premium payment made for new

[1] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. (2009). https://www.congress.gov/bill/111th-congress/house-bill/3590
[2] Paperwork Reduction Act, 45 USC 3501 et seq.
[3] 87 FR 594 (Jan. 5, 2022).

coverage to any outstanding debt owed from previous coverage and refuse to effectuate the new enrollment based on failure to pay the premium. CMS proposes this change to lessen the risk of economic hardships for low-income individuals.

Response: The federal government implemented the Exchanges, both federally-funded and state-funded, to improve health insurance coverage, accountability, and primary care access.[4] This included taking action to expand Medicaid eligibility and create tiered plan requirements - allowing consumers to select the right coverage, network, and cost for their needs.[5] Additionally, premium and cost-sharing subsidies filled the gap in affordability between full-cost insurance and Medicaid coverage[6], and a three-month grace period for late payment (before enrollment termination back to the last day of the first month of the grace period) was incorporated to further address financial concerns[7].

By requiring the healthcare system to absorb increased losses from consumer non-payment, anti-competitive risks increase. Restricting the ability for issuers to collect premiums owed and forcing insurers to either pay the costs and fees associated with collection efforts or write-off the amount owed heightens the risk for either increased consumer cost as issuers will likely pass down these costs as rates increase or, alternatively, insurer collapse. The Exchange contains subsidies as a means of financial assistance and the federal government did not intend for QHPs to replace Medicaid[8].

As supported by the above concerns, AAAHC urges CMS to maintain its current interpretation for guaranteed availability requirements under the same reasoning CMS provided in 2017: encouraging continuous coverage helps to stabilize the risk pool and individuals experiencing a change in the financial situation should submit updated financial information to the Exchange for review of new or additional subsidy eligibility[9] or Medicaid eligibility.

E. Part 156 – Health Insurer Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

9. QHP Issuer Participation Standards (§ 156.200)[10]

Request: CMS proposes an update to QHP issuer Standards requiring issuers to follow the updated prohibition on discrimination for sexual orientation and gender identity.

Response: AAAHC maintains that Standards must have clear elements for determining compliance. While AAAHC supports nondiscrimination and the reduction of disparities in health care, it is unclear how the data collection activities proposed by CMS will result in documentation that either identifies when discrimination has occurred or proves that discrimination has not occurred. Because data collection alone cannot prove non-discrimination, AAAHC does not support adding the prohibition against discrimination for sexual orientation and gender identity as a Standard but does support requiring issuer nondiscrimination policies to address the updated prohibition.

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[4] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. (2009). https://www.congress.gov/bill/111th-congress/house-bill/3590
[5] Ibid.
[6] Ibid.
[7] 45 CFR 156.270
[8] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. (2009). https://www.congress.gov/bill/111th-congress/house-bill/3590
[9] 82 FR 18351 (Apr. 18, 2017)
[10] 87 FR 671 (Jan. 5, 2022)

10. Standardized Options (§ 156.201)[11]

Request: CMS proposes to require FFE and SBE-FP participating QHP issuers to offer a standardized QHP option at every product network type, metal level, and service area that the issuer offers non-standardized QHP options. CMS is considering future limitation of the number of non-standardized QHP options that issuers can offer through the Exchange.

Response: CMS discontinued standardized plans in 2019[12] to prevent destabilization of the individual market. In this proposal, CMS provides that, since the discontinuation, the Exchange has seen an increase in the number of issuers offering plans, a decrease in the number of counties with offerings from only a single issuer, and an increase in the number of plan options consumers can access. At this time, CMS states that a reintroduction of standardized plans might enhance the consumer experience, increase consumer understanding, simplify plan selection, and advance health equity. However, CMS does not present data to support this suggestion, and the effects seen in the marketplace after CMS discontinued standardized plans appears to suggest the opposite conclusion.

AAAHC urges CMS to give a proper analysis of the burden these standardized plan requirements may have on issuers. That an issuer might have to develop eight additional standardized plans per service area to receive approval for Exchange participation in CY2023 creates a large administrative burden and could reduce participation and therefore competition within the Exchange if issuers are unable to meet the requirement. Additionally, some issuers might need to navigate two or more requirements, as the proposal requires FFE and SBE-FP participants to offer standardized options to match all non-standardized offerings while allowing State Exchanges to implement their own standardized option requirements and providing an exemption for FFE and SBE-FP states who have implemented state-level standardization options before January 1, 2020.

In the proposal, CMS recognizes the existence of alternative methods for the facilitation of more meaningful consumer choice other than standardization requirements, such as limiting the number of allowable plans an issuer may offer by metal level or through the creation of meaningful difference Standards. AAAHC believes that implementing either or both alternatives provides a greater likelihood of creating increased meaning for consumers without necessarily increasing the number of consumer plan offerings or the level of burden faced by issuers.

11. Network Adequacy (§ 156.230)

c. FFE Network Adequacy Standards Beginning with PY 2023

ii. Time and Distance Standards[13]

Request: CMS seeks comment on the agency's proposal to maintain general consistency with the Medicare Advantage program while ensuring that issuers meet the needs of the FFE population through the addition of four new specialties (emergency medicine, outpatient clinical behavioral health, pediatric primary care, and urgent care). Evaluation of network adequacy Standards for the required Individual Provider Specialty Types would be based on specified time and distance requirements calculated at the county level and varied by a county designation based upon population size and density parameters.

[11] 87 FR 671 (Jan. 5, 2022)
[12] 83 FR 16930 (Apr. 17, 2018)
[13] 87 FR 680 (Jan. 5, 2022)

Response: AAAHC supports CMS in its oversight responsibilities, including ensuring that QHP enrollees have a sufficient network of providers to allow for timely access to care. We also appreciate the efforts to maintain consistency across the CMS programs by aligning with the Medicare Advantage network adequacy Standards to the greatest extent possible while also ensuring the unique needs of different populations are met.

Additional items AAAHC urges CMS to consider include the frequency and logistics behind updating county designations and how large counties that incorporate both rural and metro areas will fit into the analysis.

iii. Appointment Wait Times[14]

Request: CMS proposes to identify a short list of provider types and/or service categories to assess for appointment wait times as an indicator of network adequacy, allowing issuers to attest to compliance with wait time requirements and implementing post-certification reviews to monitor compliance, either through access to care complaints or random samplings. Additionally, issuers unable to meet the appointment wait time requirements would be able to submit a justification that accounts for the variances.

Response: AAAHC notes that multiple providers will fall under both the "time and distance" and "appointment wait time" network adequacy measures. As more quantitative measures apply, the compliance determination becomes more complex. After reviewing CMS's proposal related to appointment wait times, AAAHC finds many questions left unanswered:

Will wait times be based on optimal, midrange, or minimally acceptable measures? Are wait times analyzed as an average per provider type and over a predetermined length of time? What is the validation process for wait time data? Who collects, maintains, and provides this data for analysis? How are variations in wait times throughout the year handled (PHE, flu season, etc.)? What is the resulting analysis where a provider or provider type meets wait time requirements but falls short of time and distance requirements, or vice versa?

AAAHC does not support the implementation of prescriptive wait time Standards due to lack of issuer control and the excessive variation that occurs (i.e., patient volume changes by season, lack of patient response resulting in increased wait time at no fault of the provider, etc.). As an accreditation organization, AAAHC's principles support trusting issuers to implement network adequacy policies that best fit their organization and network population as opposed to requiring peremptory wait time Standards that lie outside the direct control of an issuer and which are not capable of the actual calculation.

As an alternative to the prescriptive wait times proposed by CMS, AAAHC proposes the implementation of issuer policies addressing "appointment wait time mitigation", such as informing enrollees of their basic right to obtain appointments within a reasonable time, providing a complaint process, and requiring that where the issuer is timely made aware of an adequacy concern it acts sufficiently to provide relief, such as through the provision of additional resources or approval for coverage at an out-of-network provider.

[14] 87 FR 683 (Jan. 5, 2022)

v. Telehealth Services[15]

Request: CMS proposes to require all issuers offering QHPs through the FFEs to submit data regarding whether network providers offer telehealth services to advise future rulemaking related to the analysis of network adequacy.

Response: As healthcare continues to evolve, AAAHC believes it is important to consider leaving room for flexibility within quantitative standards, such as the proposed "time and distance" and "appointment wait time" requirements. AAAHC applauds the foresight of CMS regarding this consideration through the collection of provider telehealth data for analysis on the feasibility of providing network adequacy credits for telehealth capabilities. However, as CMS requests and reviews telehealth data, AAAHC encourages CMS to consider

i. the potential inequity that such network adequacy credits might create for the most rural and low-income providers and health plans, where providers and enrollees may have limited or nonexistent computer access and audio-visual communication capabilities, and

ii. the complexities in reporting and analysis that may result from the varied telehealth definitions and requirements implemented under State laws.

Alternative Suggestions Related to Network Adequacy Standards

AAAHC recognizes that different regions, population classifications, and enrollees will have differing expectations about network adequacy. While some standards for adequacy must exist and issuers should ensure their provider network does not create or foster inequity, AAAHC proposes that it may be more important to ensure that enrollees are provided with up-to-date, easy-to-access, easy-to-interpret network information from issuers before enrollment.

Is it feasible for potential enrollees to input their address and the Exchange returns a visual representation of providers and provider types available within a set distance or a graph showing the number of providers by provider type within a specified distance from their home? Could enrollees change plans outside of the open enrollment period where the network they selected has significantly reduced since their enrollment?

AAAHC suggests that quantitative network adequacy Standards may be best treated as minimal thresholds for Exchange participation and that improved network transparency and network adequacy protections for consumers would provide greater facilitation of meaningful consumer choice.

14. Standards for Downstream and Delegated Entities (§ 156.340)[16]

Request: CMS proposes all QHPs maintain full responsibility for delegated entity compliance with Standards. Currently, downstream compliance requirements are only applicable to FFE and SBE-FP issuers, but CMS proposes to expand the requirement to include State Exchange and SHOP QHPs.

Response: AAAHC believes that all QHP issuers should maintain full responsibility for downstream compliance with federal Standards but does not support the imposition of required contract terms, believing that each organization should remain free to contract in a manner governed by their unique

[15] 87 FR 684 (Jan. 5, 2022)
[16] Ibid, 686

tolerance for risk.

i. As an alternative means to the same end, AAAHC supports requiring:

ii. written delegation agreements with performance report expectations for content and frequency,

iii. Protected Health Information (PHI) requirements with HIPAA compliant data exchange,

iv. adequate sharing of member and provider data, and

v. documented and recorded annual audits of each delegated entity's performance, which the issuer properly distributes for review and approval by the issuer's governing body.

G. Solicitation of Comments on Health Equity, Climate Health, and Qualified Health Plans[17]

Request: CMS requests guidance on how the agency can incorporate health equity Standards into QHP accreditation. Should CMS require NCQA health equity accreditation in addition to other accreditation requirements? What are alternatives to this proposal? What challenges will issuers face with additional accreditation requirements? What are appropriate measures? Should QHP issuers be accountable for Social Determinants of Health (SDOH) and equity? How can CMS incentivize QHP health equity advancements outside of certification requirements? What challenges/strategies are there for QHP promotion and advancement of health equity? What population factors, health conditions, or outcome variables data can CMS leverage to analyze equity through QHPs? What other health equity tools are available outside of NCQA accreditation?

Response: AAAHC supports all active participants in the United States healthcare marketplace maintaining a level of accountability for SDOH and health equity. For issuers, this may include sufficient contracting with Essential Community Providers (ECPs), maintaining policies for the prevention of discrimination, the development of provider networks that better reflect the needs of underserved populations/communities, and incorporating health equity into the annual Quality Improvement Strategy (QIS) – each of which CMS has already incorporated within this proposal. Additional opportunities to incorporate equity into QHP requirements include increasing contracted provider types (to include midwives and doulas, for example), incentivizing provider attendance at diversity trainings (learning to better serve diverse enrollees and those facing language barriers), and extending current cost-sharing protections where disparities and monetary barriers have proven to exist.

AAAHC does not support the CMS proposal to mandate health equity accreditation for QHPs. AAAHC supports President Biden's policy that agencies should promulgate rules that promote competition and allow market entry of new competitors. Where States have required health equity accreditation from a singular identified Accreditation Organization (AO), AAAHC client organizations have opted to switch accreditation organizations based on the difficulty of managing multiple accreditation requirements across multiple AOs, effectively rendering the issuer's determination of which AO best fits the mission and culture of their organization inconsequential. AAAHC believes that any requirement naming a single approved AO creates a significant and undue barrier to other health plan accreditors and negatively affects competition and innovation within the AO market.

AAAHC proposes that different is not equivalent to better. Where one AO might choose to create a separate accreditation program for health equity, other AOs might choose to incorporate health equity into the interpretation of their existing Standards or add new equity Standards into their current

[17] 87 FR 693 (Jan. 5, 2022)

accreditation program. The unique choices made by each AO regarding how to incorporate SDOH and equity concerns into their programs should not result in discrimination against AO program selection without adequate review and supporting data.

If CMS believes the variety of other proposed requirements is insufficient, as an alternative solution to requiring specific health equity accreditation, AAAHC proposes that CMS creates and publishes QHP health equity Standards, allowing AOs a reasonable time to meet or exceed the new Standards for continued approval as an accrediting body.

Request: CMS recognizes that climate change has an increased impact on vulnerable populations and requests information related to how QHP issuers can assist in reducing the effects of climate change on enrollees, such as alerting enrollees to climate change events and providing tips on the mitigation of harmful effects.

Response: AAAHC suggests that these functions fall under the responsibility of public health officials. Although plan issuers can choose to provide these services as an added value for their enrollees to set their brand apart within the QHP market, requiring an issuer to detract limited funds from enrollee care and quality efforts prioritized by their organization seems onerous and arbitrary without data supporting the necessity of such a requirement.

Additional Suggestions to Limit the Burden on Issuers

AAAHC believes that many issuers will need additional time to update computer systems and processes in order to comply with the proposed collection of additional data elements involving provider telehealth services and the changes in de minimis coverage levels. To ensure an appropriate length of time for issuers to come into compliance, AAAHC requests CMS to consider postponing the reporting of telehealth data and issuer compliance with new de minimis levels until CY 2024.

For any questions regarding this comment, please contact Ann Carrera, Senior Counsel, Corporate Affairs at 847-853-6060 or acarrera@aaahc.org.

Sincerely,

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