AAAHC

ACCREDITATION ASSOCIATION
*for* AMBULATORY HEALTH CARE, INC.

January 8, 2024

Ms. Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9895-P
P.O. Box 8016
Baltimore, MD 21244-8016

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

RE: CMS-9895-P
RIN 0938-AV22

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 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program.

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, consultative, peer-based, and educational survey process to advance patient care. These values hold true today, as embodied in our mission statement: *Improving health care quality through accreditation*. With more than 6,700 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), and Indian Health Services (IHS) funded health centers. 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. E.O. 14036 requires that all federal agencies consider the influence their regulations, particularly licensing regulations, will 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 HHS 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 supports the HHS intention to improve access to care (through the proposed changes across 42 CFR 435.601, 42 CFR 600.320, 45 CFR 155.410, and 45 CFR 155.420) and to increase consumer understanding and the appropriate monitoring of delegated activities (through the proposed changes across 45 CFR 155.205, 45 CFR 155.302, 45 CFR 155.220, and 45 CFR 155.221).

**Specific Feedback to ICRs**

***III. Provisions of the Proposed Regulations***

***C. 45 CFR Part 153 – Standards Related to Reinsurance, Risk Corridors, and HHS Risk Adjustment4. Non-Standardized Plan Option Limits (§ 156.202)***

***5. Audits and Compliance Reviews of Risk Adjustment Covered Plans (§ 153.620(c))***

AAAHC implemented its transformational *1095 Strong*, quality every day philosophy, a call-to-action that equips our accredited organizations with the best of what is needed to operationalize quality practices. The *1095 Strong* initiative centers on providing accreditation tools, resources, and relevant education to bring meaningful value to organizations and promote compliance with AAAHC Standards, all 1,095 days of the accreditation cycle. From the time an organization submits the application to the time of the survey and beyond, AAAHC supports high-quality health care through accreditation with its *1095 Strong* drivers based on the AAAHC drive for continuous improvement. Any organization pursuing and maintaining AAAHC Accreditation is expected to assess its own ongoing compliance with AAAHC Standards and alignment with local, state, federal statutory or regulatory requirements and its own policies. AAAHC asserts that each organization is responsible to implement corrective action to maintain compliance with AAAHC Standards in order to receive or maintain AAAHC Accreditation. Failure to implement effective correction action may result in denial of accreditation or revocation of the organization's accreditation term. In line with the shared mission between HHS and AAAHC, AAAHC supports HHS in the promotion of continuous improvement within the QHP program.

[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.

***D. 45 CFR Part 155 – Exchange Establishment Standards and Other Related Standards under the Affordable Care Act***

***2. Election to Operate an Exchange after 2014 (§ 155.106)***

AAAHC supports improved transparency across federal and state programs and agrees that public notice creates an important opportunity for input and coordination. AAAHC appreciates the agency's acknowledgement that States would benefit from having a more transparent process to facilitate input from interested parties, especially given the impacts of a State Exchange transition on interested parties, including consumers and issuers.

***19. Establishment of Exchange Network Adequacy Standards (§ 155.1050)***

In 2023, AAAHC stated its support of the HHS intention to use lowest tier networks as the baseline for determinations of network adequacy. AAAHC supports HHS 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 agency's 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 HHS 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. The proposed justification process will play an important role in addressing these concerns, helping to ensure that set quantitative values do not create problems for issuers and providers in areas where access to care might be limited.

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. Related to appointment wait times, AAAHC suggests that many questions remain 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 (e.g., 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 HHS, 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.

As health care 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 HHS 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 HHS requests and reviews telehealth data, AAAHC encourages the agency 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.

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.

### *E. 45 CFR Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges*

### *3. Provision of EHB (§ 156.115)*

AAAHC supports the coverage of dental services across all HHS programs. It is widely accepted that dental health is integral to, and directly correlates with, overall health, making preventative dental care coverage a vital benefit that has been overlooked for too long. The bacterial infection Streptococcus mutans, commonly found in the mouth and significantly increasing tooth decay, has been found to infect nearly every person by adulthood[3]. Streptococcus mutans is the most prevalent bacteria found in extirpated heart valve tissues and atheromatous plaques[4] and has also been associated with infective endocarditis[5]. It is estimated that 42% of U.S. adults suffer from periodontal disease, a chronic inflammatory condition resulting in bone loss, loose teeth, and painful, swollen gums[6]. And, both within the U.S. and throughout the world, occurrence rates of mouth and throat cancer are increasing[7].

[3] Marcenes W, Kassebaum NJ, Bernabé E, et al. Global Burden of Oral Conditions in 1990-2010: A Systematic Analysis. Journal of Dental Research. 2013;92(7):592-597. doi:10.1177/0022034513490168
[4] Nakano K, Inaba H, Nomura R, et al. Detection of cariogenic Streptococcus mutans in extirpated heart valve and atheromatous plaque specimens. J Clin Microbiol. 2006 Sep;44(9):3313-7. doi: 10.1128/JCM.00377-06. PMID: 16954266; PMCID: PMC1594668
[5] Toda M, Yamaguchi M, Katsuno T, et al. Streptococcus mutans-induced infective endocarditis associated with hypocomplementemia and positive anti-double-stranded DNA antibody. J Clin Rheumatol. 2021 Jan 1;27(1):e15-e16. doi: 10.1097/RHU.0000000000001205. PMID: 31743271
[6] Eke PI, Thornton-Evans GO, Wei L, et al. Periodontitis in US adults: national health and nutrition examination survey 2009-2014. J Am Dent Assoc. 2018 Jul;149(7):576-588.e6. doi: 10.1016/j.adaj.2018.04.023. PMID: 29957185; PMCID: PMC8094373
[7] Rodríguez-Gómez IM, Gómez-Laguna J, Ruedas-Torres I, et al. Global, regional, and national prevalence, incidence, and disability-adjusted life years for oral conditions for 195 countries. Veterinary Pathology. 2017;96(4):574-577. doi:10.1177/0300985821991565

Income inequality is associated with lower oral health and a reduced quality of life. Lack of oral health care has been shown to impact the way others treat low-income persons and results in a lessened ability to obtain employment[8]. Furthermore, as publicly insured or uninsured patients[9] help drive emergency department visits for the treatment of acute tooth pain to more than 2.4 million annually, it can hardly be denied that increased costs and a general lack of access to dental care are negatively impacting both beneficiaries and the health care system as a whole. Dental services are inextricably linked to whole-person care, are integral to reaching our national health equity goals, and should not be limited to pediatric oral care.

To move oral health and primary care integration forward, dental coverage must be considered an integral component of health insurance – not an optional benefit. State Medicaid programs are now required to include dental coverage for adults and children and are expected to include oral health in value-based payment arrangements. However, QHP requirements have not been expanded to include these oral health and dental services. This care must become a priority if all persons are going to receive equal access to care.

***6. Standardized Plan Options (§ 156.201)***

AAAHC would like to state its support of the HHS efforts to simplify and streamline plan options for consumers. In the proposal, HHS 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. The agency discontinued standardized plans in 2019 to prevent destabilization of the individual market, and reimplemented standardized plans in 2023. In the 2023 proposal, the agency provided 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. HHS stated that a reintroduction of standardized plans might enhance the consumer experience, increase consumer understanding, simplify plan selection, and advance health equity. However, the agency did not present data to support this suggestion, and the effects seen in the marketplace the 2019 discontinuation of standardized plans appeared to suggest the opposite conclusion. Within the current proposal, HHS identifies that regardless of the intent behind the reintroduction of standardized plan requirements, continued plan proliferation has only continued to increase.

AAAHC urges HHS to give a proper analysis of the burden these standardized plan requirements may have on issuers. Increased administrative burden could reduce participation and therefore competition within the Exchange if issuers are unable to meet the requirement. Additionally, some issuers might need to navigate multiple requirements, as the current standardization requirements mean that FFE and SBE-FP participants must 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 had implemented state-level standardization options before January 1, 2020.

[8] Moeller J, Starkel R, Quiñonez C, Vujicic M. Income inequality in the United States and its potential effect on oral health. J Am Dent Assoc. 2017 Jun;148(6):361-368. doi: 10.1016/j.adaj.2017.02.052. Epub 2017 Apr 18. PMID: 28427720

[9] Allareddy V, Rampa S, Lee MK, et al. Hospital-based emergency department visits involving dental conditions: profile and predictors of poor outcomes and resource utilization. J Am Dent Assoc. 2014 Apr;145(4):331-7. doi: 10.14219/jada.2014.7. PMID: 24686965

In the 2024 proposal, HHS recognized 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. Consistency should increase consumer understanding and ease of use. 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, and AAAHC encourages the agency to give further consideration to these alternatives.

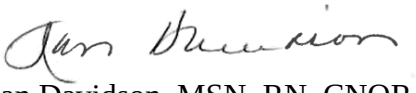
***7. Non-Standardized Plan Option Limits (§ 156.202)***

In line with our previous commentary, AAAHC would like to state its support of the HHS efforts to simplify and streamline plan options for consumers, with caution that non-standardized plan limitations should not impact the ability for members to afford the purchase of QHP plans on the Exchanges. In previous proposals, HHS recognized 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.

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

Sincerely,

Noel M. Adachi, MBA
President & CEO



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