AAAHC

ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

November 12, 2024

Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9888-P
P.O. Box 8010
Baltimore, MD 21244-8010

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

RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program (RIN 0938-AV41)

Dear Administrator Brooks-LaSure,

The Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) greatly 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 2026; and Basic Health Program.

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 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 Resources and Services Administration (HRSA), and Indian Health Service (IHS) funded health centers. Other AAAHC-Accredited Organizations include Ambulatory Surgical Centers, Community Health Centers, Tribal Health Centers, Student Health Centers, Medical Group Practices, and Office-based Surgery Centers.

3 Parkway North, Suite 201
Deerfield, Illinois 60015
TEL 847.853.6060
FAX 847.853.9028
www.aaahc.org
info@aaahc.org

General Statement of Support

AAAHC would like to express our support for the following proposals:

- Certification Standards for QHPs (§155.1000) (89 FR 82369), allowing an Exchange to deny QHP certification to any health plan not meeting certification criteria;
- Request for the Reconsideration of Denial of Certification Specific to the FFEs (§155.1090) (89 FR 82370), providing additional structure for insurer certification application reconsideration request submissions;
- Reducing the Risk that Issuer Insolvencies Pose to the Integrity of the FFEs (89 FR 82371), considering the potential for HHS to partner with State Departments of Insurance and the National Association of Insurance Commissioners to reduce the risk of issuer insolvency within the FFEs; and
- Non Standardized Plan Option Limits (§156.202) (89 FR 82382), specifying that issuers have the operational flexibility to vary the inclusion of adult dental coverage, pediatric dental coverage, and adult vision coverage within their nonstandardized plan offerings.

III. Provisions of the Proposed Regulations (89 FR 82317)

C. Part 155—Exchange Establishment Standards and Other Related Standards (89 FR 82356)

9. General Program Integrity and Oversight Requirements (§ 155.1200) (89 FR 82371)

CMS has proposed to publish annual State-based Marketplace Annual Reporting Tool compliance reports (SMARTs), financial/programmatic audits, and corrective action/open finding documentation for State Exchanges and State Based Exchanges on the Federal Platform (SBE-FPs) and to expand current Open Enrollment data publication by including additional metrics that are already being collected on State Exchange operations and functionality, such as spending on outreach, eligibility and enrollment policies/processes, plan certification requirements, and operational performance data. The intentions behind this proposal include increased transparency and improved public understanding of State Exchanges. CMS requests comment related to this proposal and additional metrics that would be useful to disclose to the public.

Generally, AAAHC supports increased transparency. However, increased transparency must be balanced against the likelihood of causing additional confusion and misinterpretation of the data. This proposal to publicize a variety of additional information in CY 2025 does not include specific details on what the data is intended to guide or how the public is expected to use the information.

While eligibility and enrollment details, plan certification requirements, and operational performance data may be helpful to consumers if presented in a meaningful manner that is easy to interpret, details such as financial reports, programmatic audits, and corrective actions/open findings are less likely to be beneficial. For example, open findings documentation provides data this is only representative of a single snapshot in time, which is unlikely to offer a clear picture of corrective actions the plan is undertaking to remedy the situation and therefore, could drive inaccurate perceptions of the plan or carrier.

AAAHC supports this proposal with the recommendation that any information published by CMS for use by the public should be offered with instructions related to how the information is intended to be used and presented in a manner that allows clear and accurate interpretation or comparison, focusing on standardized metrics such as call center statistics, timely resolution of grievances, appeals determinations, and claim payment accuracy.

D. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges (89 FR 82371)

6. Standardized Plan Options (§156.201) (89 FR 82378)

CMS proposes minor updates to standardized plan designs for CY 2026, with the goal of ensuring that plans continue to have Actuarial Values (AVs) within the permissible de minimis range for each metal level. CMS also wants to ensure that issuers offering multiple standardized plan options within the same network type, metal level, and service area meaningfully differentiate each plan in terms of included benefits, provider networks, and/or formularies. CMS seeks comment on this modified approach to standardized plan options.

AAAHC supports meaningful difference standards between plan options as a way to create improved meaning for consumers and prevent overflooding of the market. Simplification of the plan selection process is helpful to beneficiaries and has the potential to reduce inequities by offering clarity and ease of distinction between available plan options.

8. Essential Community Provider (ECP) Reviews for States Performing Plan Management (§156.235) (89 FR 82385)

CMS has proposed to conduct ECP certification reviews for Federally Facilitated Exchange (FFE) QHPs in states that perform plan management functions. This ECP certification review is proposed to be implemented due to operational capabilities now allowing insurers to directly submit ECP data through the HIOS MPMS. CMS intends to use this data submission to validate ECP data prior to its display on the Exchange in support of consumer access to vitally important medical and dental services and health equity for low-income and medically underserved consumers. CMS seeks comment on this proposal.

AAAHC supported the implementation of improved ECP network adequacy requirements for QHPs to improve beneficiary access to critical services. Due to the importance of ensuring access to care for the insured, AAAHC also supports CMS in its decision to audit ECP data for compliance with the agency's requirements. We also respectfully recommend that CMS plan and scope the ECP audits in a manner that allows performance of the audit within current budget and staffing limitations, to ensure the commitment of reviewing ECP adequacy is able to be fulfilled.

9. Quality Improvement Strategy (§156.1130) (89 FR 82385)

CMS proposes to publicize aggregate, summary level Quality Improvement Strategy (QIS) information annually in support of increased transparency. CMS believes this will drive innovation and quality improvement across Exchanges, strengthen alignment across quality reporting and value-based incentive programs, and encourage learning to inform best practices for quality improvement. Assurance was provided that the agency would comply with its privacy policies and all confidential data would be carefully redacted and omitted, with publication only in an aggregated and summary format. CMS seeks comment on this proposal, the types of QIS data to release in an annual report, and other potential mechanisms for presenting QIS information in a manner that is informative to both issuers and consumers.

AAAHC's commentary in response to the proposed changes under §155.1200, as set forth in proposal section III.C.9., are also applicable to the proposed QIS public reporting changes. In CMS's request for comments here, the intention is for the public QIS data to be useful to both issuers and consumers. However, these audiences are significantly different and would use the information provided for very different purposes.

While many of the proposals made by CMS over the past few years have focused on reducing consumer confusion when attempting to select health insurance coverage through an Exchange plan, the additional proposals for public reporting of data seem counterintuitive to that goal. Many of the proposals to improve transparency through increased data publication are not specific as to the intent behind the additional information or how it will be presented to consumers in a manner that assists in the comparison of plan details. Although additional information and data can be meaningful, too much data can easily become overwhelming and work in contrast to the intention of improved transparency and clarity. Without a proper strategy, including what is being shared with whom and how, additional information is quite likely to result in confusion. Furthermore, if different information is going to be useful to issuers than to consumers, this data should be separated based on the intended audiences.

Prior to finalization of this proposal, AAAHC would like to see additional details related to ensuring the QIS data is consistent across all plans, which specific data points CMS is intending to make available to the public, why that information is considered to be relevant to the intended audience, and how the data will be presented in a meaningful and purposeful manner. Having this information available will allow for consideration of the impact specific data may have on the public and give the opportunity for more meaningful insights within comment responses. Additionally, CMS may consider displaying the selected data for a limited period of time, such as one year, and then removing data that is not reported to play a meaningful role in consumer plan decisions.

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
President & CEO