December 21, 2015

Andy Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
200 Independence Ave., SW
Washington, DC 20201

RE: HHS Notice of Benefit and Payment Parameters for 2017 (CMS-9937-P)

Dear Administrator Slavitt:

The American Academy of PAs (AAPA), on behalf of the more than 104,000 PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments on the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Proposed Rule. Of particular interest to PAs are the provisions in the rule regarding network adequacy standards for Qualified Health Plans (QHPs) in the exchanges. PAs are dedicated to improving patient access to care and are particularly interested in the appropriate development and implementation of network adequacy policies that promote access to both primary and specialty care within the patient's health plan network. We know that simply giving a health insurance card to a patient is not enough to ensure adequate access to care. AAPA believes network adequacy occurs when patients have timely access to the appropriate health professional in a setting that is both convenient and cost effective. It is within this context that we draw your attention to our comments regarding network adequacy.

Each year PAs are responsible for millions of patient visits in all specialties and in nearly every healthcare setting. However, those PA-provided visits are often not recognized as being delivered by a PA because of how the services are billed. Frequently the services are billed under the name and provider number of the physician. If only the claims or billing data is examined, then the presence of PAs might be missed. Any attempt to accurately determine which health professionals are available to deliver care to patients must include the recognition of professionals such as PAs.

Minimum Threshold

In the proposed rule, the Centers for Medicare and Medicaid Services (CMS) propose the creation of a quantitative network adequacy threshold or benchmark. States, that review QHPs for network adequacy and enforce network adequacy standards, would be allowed to select a threshold that they believe suits their needs, pending approval by the US Department of Health and Human Services (HHS). HHS would provide each state with a list of acceptable network adequacy metrics from which it can choose. If a state does not select a threshold, the state's standards for network adequacy will default to a federal standard, likely consisting of a county-specific time and distance standard. If a QHP is unable to meet a state's standards the QHP can submit justifications for the need for a variance to the network adequacy requirements directly to the Federally-facilitated Exchange (FFE) for review.

AAPA appreciates the flexibility of allowing states to choose the network adequacy standards they believe to be most appropriate. However, we strongly recommend that HHS maintain high standards if states decide to develop their own network adequacy standards in order to protect consumers and ensure sufficient patient access.

CMS also indicated that the federal default time and distance requirements would, similar to Medicare Advantage, use the NPI database. This method would indicate what health professionals are available within a given area. However, adequacy data can be further strengthened by collecting information on which health professionals are actually providing care within that area. Consequently, if QHPs are collecting NPI information on all available health professionals to determine geographic location, it is essential that QHPs require health professionals to submit claims using their NPI as rendering provider to create an accurate depiction of who is actually providing care.

Finally, AAPA would like to recommend that, for those QHPs that fail to meet the network adequacy minimum threshold, CMS should properly explain why the network is insufficient and provide recommendations to rectify network composition in order to meet threshold requirements. One recommendation that may boost network adequacy is an examination of a QHP's policies to see that healthcare professionals such as PAs are being allowed to practice to the full extent of their education, and state law. Fully utilizing PAs and other health professionals will increase the number of practitioners able to provide care and likely increase access as a result. Another recommendation that could be made to QHPs is to incentivize health professionals like PAs, who often work in rural areas where concerns of network adequacy are exacerbated, to join the network.

Out-of-Network Cost Sharing

CMS' proposed rule would require that each QHP that utilizes a provider network choose one of two options if an enrollee at an in-network setting is to be provided an essential health benefit (EHB) by an out-of-network health professional. Either the QHP must provide the patient with a minimum of ten days' notice of the situation before care is delivered, or, if this is not possible or not done, the QHP must count any cost sharing paid by the enrollee toward the enrollee's annual cost sharing limit. This provision would apply to all QHPs in all exchanges.

AAPA is concerned that ten days is too short a time to provide notice to an enrollee who find themselves in this situation. The objective of providing 10 days' notice is to allow an enrollee to arrange for an in-network health professional to provide the EHB. We believe that patients need more time, perhaps 30 days, to find an in-network health professional. In many areas it can take several weeks to schedule an appointment with a provider. While CMS would allow any cost-sharing paid by the enrollee to count toward an annual cost sharing limit if notification isn't provided, this option is not preferable. Out of pocket limits are very high in a number of QHPs and this could add undue burden on an enrollee for a charge that could be avoided if adequate notice is provided.

In addition, AAPA believes it is insufficient for issuers to simply send a 'form document' to generically inform an enrollee that one of their health professionals is out-of-network. The absence of personalized information could either make it look like a general notice that may not affect them personally, or leave the patient confused and in search of more information as to which of their health professional is out-of-network. Instead, issuers should 'customize' these letters to an enrollee's situation. AAPA suggests QHPs be required to provide consumer/patient guidance to those enrollees who receive such a notice advising them of "next steps" in locating an in-network health professional.

Provider Transition

The proposed rule contains a consumer-protection provision which seeks to address enrollee notifications of when their health professional has left or been removed from a network. The provision indicates that a QHP in the FFE would be required to make a good-faith effort to provide written notice of a discontinued health professional 30 days prior to the effective date of the change, or as soon as practicable, to patients seen on a regular basis by the health professional. CMS encourages issuers to include in this notification a list of comparable in-network health professionals in the patient's area. AAPA believes the term "regular basis" should be defined as having had a wellness visit with the health professional at some point in the last two years, or having visited the health professional twice or more for other medical reasons. In addition, provision of a list of other comparable in-network health professionals should be required, not merely encouraged, and should include the names of all health professionals, including PAs, that are authorized to deliver the needed care.

Additional CMS Requests for Stakeholder Input

CMS is considering creating a standardized characterization of network depth for QHPs for display on healthcare.gov. This would act as a "ratings system" on network coverage, comparing plans to one another in the same geographic area. The rating would be based on data submitted by QHP issuers.

AAPA understands the value of such a display, but only if the data accurately reflects the health professionals who actually deliver care. The care delivered by PAs is not apparent due to certain billing mechanisms – such as when services provided by PAs are billed under the physician's name and when PAs are covered professionals, but not individually enrolled by QHPs. If systems used by the QHP do not appropriately recognize PAs then it is not possible to make rational decisions about network adequacy. In addition, the information used to develop the rating must be based on current data and a sufficient explanation of the rating process must be provided to consumers.

The proposed rule makes mention of a previously established regulation (45 CFR §156.230(b)) which requires QHPs to publish "an up-to-date, accurate, and complete provider directory."

AAPA supports the availability of comprehensive and accurate provider directories. We believe this provision is clearly indicative of CMS' move toward increased transparency for consumers regarding healthcare options. In order to make this information available, CMS will need to collect information on relevant health professionals for display and tracking. CMS can only achieve this by requiring health professionals, such as PAs, to be enrolled in all health plans and networks, and submit claims using their own NPI as a rendering provider for services performed.

Should a QHP be required to have a network resilience policy for disaster preparedness?

AAPA finds value in QHPs having network resilience policies for disaster preparedness. It is important that robust network availability be in place in times when healthcare may be most needed. This may require flexibility from QHPs when extraordinary circumstances make traditional boundaries of networks less important than getting patients the immediate care they need. In such unusual situations, CMS should allow patients to receive care from out-of-network health professionals without being charged out-of-network rates or co-pays.

Should an issuer be required to survey all of its contract providers on a regular basis to determine if a sufficient number of network providers are accepting new patients?

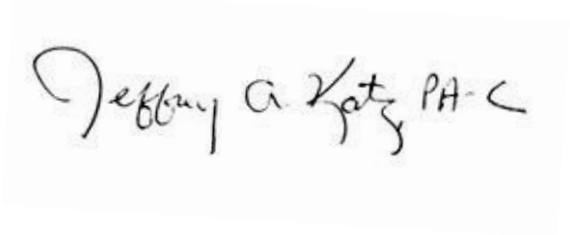
AAPA believes informing patients which health professionals are accepting new patients is necessary. Up-to-date information is essential to maintaining a relevant provider directory and determining access. If the majority of providers in a QHP are not taking new patients, then even if the QHP has met the provider thresholds for network adequacy, it is in name only because their services would not be available for new patients. Such surveys should be mindful of the type of health professionals qualified to perform particular services, capturing more than just the availability of physicians, but also professionals such as PAs who often deliver the same services provided by physicians.

Should those requirements mentioned in the proposed rule apply to all QHPs or only QHPs in the FFE?

All QHPs must already meet a 'reasonable access' network adequacy standard. FFE issuers must meet additional standards. The new category created by this rule (state-based exchange using the federal platform) must also meet the standards set for the FFE. AAPA believes the FFE standards should be uniform across all QHPs. Consistency will help reduce compliance complexity for issuers who have products across markets and programs. Meanwhile, enrollees can be sure their networks are being held to the same standard as others across the country.

AAPA appreciates the opportunity to provide feedback on network adequacy provisions contained in the Notice of Benefit and Payment Proposed Rule. AAPA welcomes further discussion with CMS regarding our thoughts, suggestions and concerns. For any questions you may have in regard to our comments and recommendations please do not hesitate to contact Michael Powe, AAPA Vice President of Reimbursement & Professional Advocacy, at 571-319-4345 or michael@aapa.org.

Sincerely,



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President and Chair of the Board