

June 5, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Request for Information Regarding Provider Non-Discrimination (CMS-9942-NC)

Dear Administrator Tavenner:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am pleased to provide our comments regarding the “Provider Non-Discrimination” provision at section 2706(a) of the Public Health Service Act, as added by section 1201 of the Affordable Care Act (ACA).¹ These comments are submitted in response to the recent Request for Information of the Department of Treasury/Internal Revenue Service, Department of Labor/Employee Benefits Security Administration, and Department of Health and Human Services/Centers for Medicare & Medicaid Services (CMS).²

The AMA is a leading and vocal advocate for the importance of physician-led health care teams. We strongly believe that in order to ensure safe, high quality health care, all health professionals must be held to the highest standard of care under scope of practice policies that appropriately match education and experience levels to particular procedures, services, and other aspects of patient care. In this vein, the AMA supports a careful interpretation of section 2706(a) that prevents any possible federal intrusion into scope of practice policies, which are generally the province of state law and regulations. Section 2706(a) has been invoked, improperly, to support expansion of scope of practice beyond current state policies. Such interpretations go beyond the letter and intent of section 2706(a) and conflict with current policy set for Medicare Advantage and Medicaid managed care plans under very similar provisions.

Section 2706(a) does not expand state-conferred scope of practice or require contracting with all types of health care providers.

Section 2706(a) prohibits certain discrimination against health care providers acting within their scope of practice as evidenced by state license or certification. The provision applies to non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage for plan/policy years that begin on or after January 1, 2014. Section 2706(a) specifically states as follows:

¹ 42 USC § 300gg-5(a)

² 79 Fed. Reg. 14051 (March 12, 2014)

(a) Providers.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

Inherent in the specific statutory language are several fundamental requirements and concepts that circumscribe the non-discrimination prohibition and build upon current scope of practice policy. These in turn prevent sweeping interpretations that this provision requires broad expansions of current scope of practice policies. Section 2706(a):

- Explicitly respects state scope of practice laws for licensing and certification of health care providers;
- Explicitly prohibits interpretations that group health plans and health insurance issuers events must contract with “any willing health care provider;”
- Explicitly allows group health plans and health insurance issuers to establish different reimbursement rates based upon quality or performance measures; and
- Does not require coverage of all services or all types of providers.

Health plans and insurers will continue to be required to contract with an adequate number, array, and geographical distribution of physicians and other practitioners to provide their members with the full complement of health services within that particular health plan and network. But section 2706(a) does not supersede state scope of practice laws that circumscribe the particular services and interventions for each type of practitioner in that particular state. It does not require health plans to cover every type of service, such as massage therapy, family counseling, and health club memberships.

Other provisions of the ACA determine which “essential health benefits” (EHBs) must be offered by health plans and insurance issuers. Section 1302(a) lists the ten categories of EHBs which non-grandfathered health insurance in the individual or small group market must include in their coverage. States in turn may identify an EHB-benchmark plan consistent with 45 CFR § 156.100. The benchmark typically selected is a large existing small group insurance product, which excludes a variety of services from coverage.

Previous interpretations of the non-discrimination provision by the administration support the foregoing approach. On April 29, 2013, the Departments of Labor, Health and Human Services, and Treasury issued Frequently Asked Questions (FAQs) to assist stakeholders in interpreting the ACA. The FAQs characterize section 2706(a) as “self-implementing” so there was no plan to issue regulations “in the near future.” More importantly, the FAQs clearly state that health plans and issuers will not be required “to accept all types of providers into a network” and remain free to set their own reimbursement rates based upon “market standards and considerations” in addition to quality and performance factors. In addition, the FAQs couch the non-discrimination prohibition in terms of items and services already covered as a benefit in a plan—clearly indicating that the provision does not require the addition of new items and services or the addition of new types of providers. Another stipulation is that the provision is to be interpreted “consistent with reasonable medical management techniques,” presumably referring to

medical necessity and appropriateness criteria which are the gold standard for determinations of insurance coverage and limitations. Here is the relevant excerpt from those FAQs:

Until any further guidance is issued, group health plans and health insurance issuers offering group or individual coverage are expected to implement the requirements of PHS Act section 2706(a) using a good faith, reasonable interpretation of the law. For this purpose, to the extent an item or service is a covered benefit under the plan or coverage, and consistent with reasonable medical management techniques specified under the plan with respect to the frequency, method, treatment, or setting for an item or service, a plan or issuer shall not discriminate based on a provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under applicable state law. This provision does not require plans or issuers to accept all types of providers into a network. This provision also does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.³

We also believe that regulations interpreting section 2706(a) should maintain consistency with the similar non-discrimination policies found in the statutes and regulations for Medicare Advantage and Medicaid managed care plans.

In the Request for Information, CMS has specifically requested comments on the interpretation of section 2706(a) in the Report of the Senate Committee on Appropriations, dated July 11, 2013, to accompany S. 1284. That report references this provision as prohibiting discrimination "against any healthcare provider who is acting" within his or her scope of practice "when determining networks." It also says the goal of the provision "is to ensure that patients have the right to access covered health services from the full range of providers licensed and certified in their State."⁴ However, S. 1284 was not enacted into law. So the referenced report does not carry the same weight as a report for a bill that actually became law. Likewise, it should not be considered to be within the legislative history for section 2706(a).

Antidiscrimination policies based on similar statutory language for Medicare Advantage and Medicaid managed care plans did not expand scope of practice policies or require contracting with all types of practitioners.

Similar "antidiscrimination" policies for Medicare Advantage (MA) plans and Medicare managed care plans, including regulations implemented in 2000 and 2002, respectively, also take a balanced approach. They specifically did not establish sweeping new requirements for contracting with every type of practitioner or offering every type of service. The statutory MA antidiscrimination provision for MA plans, at section 1852(b)(2) of the Social Security Act, explicitly protects the ability of MA plans to determine which providers are necessary to meet the needs of their enrollees and to set quality and cost controls:

³ United States Department of Labor, Employee Benefits Security Administration. *FAQs about the Affordable Care Act Implementation Part XV*. April 29, 2013. <http://www.dol.gov/ebsa/faqs/faq-aca15.html>.

⁴ Senate Committee on Appropriations. *S. Report 113-71 to accompany S. 1284, Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Bill, 2014* at 126. July 11, 2013.

(b) ANTIDISCRIMINATION.—

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(2) PROVIDERS.—A Medicare+Choice [M+C] organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measures designed to maintain quality and control costs consistent with the responsibilities of the plan.⁵

The MA regulations adopted in June 2000 (consolidating earlier provisions) allow MA organizations (other than private fee-for-service plans) to exclude professionals beyond the number needed by the plan and to vary reimbursement rates by specialty or practitioner. Moreover, they do not require contracting with every type of practitioner or for all types of services:

Provider antidiscrimination rules.

(a) General rule. Consistent with the requirements of this section, the policies and procedures concerning provider selection and credentialing established under § 422.204, and with the requirement under § 422.100(c) that all Medicare-covered services be available to MA plan enrollees, an MA organization may select the practitioners that participate in its plan provider networks. In selecting these practitioners, an MA organization may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under State law, solely on the basis of the license or certification. If an MA organization declines to include a given provider or group of providers in its network, it must furnish written notice to the effected provider(s) of the reason for the decision.

(b) Construction. The prohibition in paragraph (a)(1) of this section does not preclude any of the following by the MA organization:

(1) Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan's enrollees (except for MA private-fee-for-service plans, which may not refuse to contract on this basis);

(2) Use of different reimbursement amounts for different specialties or for different practitioners in the same specialty; and

(3) Implementation of measures designed to maintain quality and control costs consistent with its responsibilities.⁶

In the notice of final rule implementing this provision, the Health Care Financing Administration (HCFA) explained that "Our goal in implementing these changes is to strike a balance between our responsibility to ensure that M+C organizations are employing all the types of health care professionals needed to ensure that required Medicare-covered services are available to their enrollees, and our aversion to limiting organizations' flexibility in providing these services." The agency further explains:

If an M+C organization can provide all physicians' services through a doctor of medicine, it may not "need" to contract with another practitioner who can provide only a discrete subset of

⁵ 42 USC § 1395w-22

⁶ 65 Fed. Reg. 40170 (June 29, 2000)

physicians' services (such as a podiatrist or a chiropractor who under section 1861(r) of the Act are considered physicians under Medicare only for specified purposes). As long as all Medicare-covered services are available in the plan, there may be no "need" to assume the additional administrative costs of contracting with another practitioner when an existing contractor is able to perform the services the additional practitioner would be providing. This would not constitute discrimination "solely" on the basis of license or certification, but rather, not contracting with practitioners not "needed" to provide the full Medicare range of benefits.

With respect to the choice-of-practitioners provision, this right has always been inherent in the managed care model of health care delivery. While a practitioner is not to be discriminated against *solely* due to his or her license, we believe that M+C organizations must have the flexibility to deliver services through the most cost-effective practitioner who is qualified to perform the service in question.⁷

There is a similar anti-discrimination provision at section 1932 (b)(7) of the Social Security Act for Medicaid managed care organizations:

Antidiscrimination.—A Medicaid managed care organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization.⁸

Once again, CMS specifically did not issue sweeping pronouncements requiring contracting with all types of health care professionals—or for all types of services—in the regulations it issued in 2002 to interpret the statutory antidiscrimination provision for Medicaid managed care plans:

438.12 Provider discrimination prohibited

(a) *General rules.* (1) An MCO [managed care organization], PIHP [prepaid inpatient health plan], or PAHP [prepaid ambulatory health plan] may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If an MCO, PIHP, or PAHP declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.⁹

Section 438.12(b) further states that this section "may not be construed" to require MCOs, PIHPs, or PAHPs to "contract with providers beyond the number necessary to meet the needs of its enrollees" or to preclude them from "using different reimbursement amounts for different specialties or for different practitioners in the same specialty" or from "establishing measures that are designed to maintain quality

⁷ 65 Fed. Reg. at 40237-40238 (June 29, 2000)

⁸ 42 USC § 1396u-2

⁹ 42 CFR § 438.12, 67 Fed. Reg. 40989 (June 14, 2002)

of services and control costs and are consistent with its responsibilities to enrollees.”¹⁰ CMS further clarified the limitations of this provision in the notice of final rule implementing the new regulation:

Proposed 438.12 would implement the prohibition on provider discrimination in section 1932(b)(7) of the Act. The intent of these requirements is to ensure that an MCO does not discriminate against providers, with respect to participation, reimbursement, or indemnification, solely on the basis of their licensure or certification. We extended this requirement to PIHPs and PAHPs in proposed § 438.12. These requirements do not prohibit an MCO, PIHP or PAHP from including providers only to the extent necessary to meet their needs. Further, the requirements do not preclude an MCO, PIHP or PAHP from establishing different payment rates for different specialties. Further, this provision does not preclude these entities from establishing measures for provider selection that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.¹¹

The AMA supports the contributions of non-physician practitioners, working within their state scope of practice, as part of physician-led teams.

The AMA supports the use of patient-centered, team-based patient care in which physicians and other health professionals work together, sharing decisions and information, for the benefit of the patient. In particular, the AMA believes that physician-led health care teams can optimize prevention, population management, care coordination, and the avoidance of unnecessary referrals, procedures, emergency department use and hospitalizations.

The AMA recently commissioned RAND Health to study factors affecting physician professional satisfaction and implications for patient care, health systems, and health policy.¹² After interviewing and surveying physicians, other health care professionals and staff, RAND found that working with adequate numbers of well-trained, trusted, and capable non-physician clinicians and support staff enhances physicians’ professional satisfaction and the sustainability of their practices. This interaction enables physicians to achieve a more desirable mix of work content, and such working relationships can span decades. Inherent in the RAND findings are the joint concepts of the health care team working together and every team member utilizing his or her training and clinical expertise.

Licensure and certification serve an important function in health care. Consumers face serious risks if they are treated by unqualified individuals, and it can be difficult, if not impossible, to adequately assess quality of care at the time of delivery.¹³ The states have traditionally regulated the practice of medicine and other health care practices of non-physicians through distinct licensure and certification requirements. The purpose of these requirements is to ensure the safety of patients in receiving such care. States have been entrusted to ensure that individuals providing health care services are academically qualified, have completed the necessary training, and are evaluated for their clinical acumen.

¹⁰ Id.

¹¹ 67 Fed. Reg. 41018-41019 (June 14, 2002)

¹² AMA-RAND. *Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy.* October 2013.

¹³ Federal Trade Commission. *Competition and the Regulation of Advanced Practice Registered Nurses.* March 2014.

Conclusion

We urge CMS to clarify, consistent with the statutory language in the ACA and with Medicare Advantage and Medicaid policies, that section 2706(a) does not go beyond existing Medicare or Medicaid rules regarding the scope of practice of particular types of practitioners, nor does it require health plans and issuers to contract with particular types of practitioners or cover all types of services. Some interpretations of this provision appear to see it as a breakthrough that will require health plans to cover virtually all services provided by every type of licensed health care practitioner. We believe that is not what Congress intended, nor would it be sound public policy. Like Medicare, health plans must have the necessary flexibility to be able to pick and choose particular services and professionals to meet the needs of their beneficiaries, in order to maintain costs within reasonable limits, as well as to ensure that services are provided by the appropriate professionals. Section 2706(a) must be interpreted consistently with similar longstanding non-discrimination policies that allow Medicare to determine which practitioners can be reimbursed for particular services, and allow Medicare Advantage and Medicaid managed care plans to select particular practitioners or types of practitioners with whom to contract.

Sincerely,

James L. Madara, MD