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January 27, 2022

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

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, CMS-9911-P

Dear Administrator Brooks-LaSure:

The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the proposed rule entitled "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023," 87 *Fed. Reg.* 584 (January 5, 2022) issued by the Centers for Medicare & Medicaid Services (CMS or the Agency). The AAMC supports CMS's efforts to ensure that consumers have access to high-quality providers by improving network adequacy, time and distance, and essential community providers standards for qualified health plans (QHPs) offered through federally-facilitated Exchanges (FFEs) and State-based Exchanges on the Federal platform. The Association also supports meaningful expansion of telehealth to allow consumers another option to access to needed medical care.

The AAMC is a nonprofit association dedicated to transforming health through medical education, health care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals employed across academic medicine, including more than 186,000 full-time faculty members, 94,000 medical students, 145,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

NETWORK ADEQUACY

Robust Networks Ensure Patients' Access to a Greater Number of Providers

The AAMC supports the proposal to strengthen network adequacy requirements for Exchange plans. The AAMC believes that it is essential that QHP network standards be structured so that there are sufficient providers and facilities included in a plan's network to ensure adequate access to a range of care, including specialty care and tertiary/quaternary care, for consumers. Allowing networks to be constructed in a manner that discourages access, and thus enrollment in a plan, penalizes consumers with unique or high-cost conditions. Insurers claim that replacing robust provider networks with narrower networks lowers enrollees' expenses such as premiums and cost sharing. However, narrow networks limit patients to a select number of providers and hospitals, often decreasing access to hospitals and physicians that provide specialized care.

Limiting patients' access to certain providers can be particularly detrimental for patient groups that already suffer from disproportionate levels of disease and death. In order to make inroads on improving the health and well-being of individuals, meaningful partnerships with local communities are paramount. That includes providing access to high-quality care for patients by ensuring that robust provider networks are offered by issuers providing plans on the Exchanges.

Teaching hospitals and their associated physicians and other providers are an important part of ensuring access to high-quality, cutting-edge treatments. However, teaching hospitals and their associated faculty physicians are sometimes excluded from insurer networks. Excluding these institutions and physicians limit patients' access to specialized and sub-specialized care that often is only furnished at teaching hospitals. Ensuring that Exchange plans have robust provider networks, including teaching hospitals and their associated providers, will safeguard consumers' access to a greater number and type of providers, to meet their health care needs.

Prohibitions on Certain Contract Clauses Will Limit Patients Access to Providers

The proposed rule seeks comments on how "limiting 'all or nothing' contracting provisions in payer contracts might counteract the potential for stronger network adequacy standards to increase health care costs." (p 684-5). The rule calls out anti-steering and all-or-nothing contracting provisions as problematic. **These important contractual clauses ensure patients have access to needed medical care. Providers should not be prohibited from including these clauses in contracts with insurers.**

Provider contract negotiations are complex discussions that involve nuanced tradeoffs of payment amounts, patient mix, volume, services, and many other variables – each of which is connected to a dollar amount and subject to negotiation. Both providers and insurers use specific contractual language to modify these variables to reach an agreement that is mutually beneficial to both parties. For example, providers often accept lower in-network reimbursement rates in exchange for higher patient volume or additional payments based on quality. Removing the ability of providers to use anti-tiering, anti-steering, and all-or-nothing clauses in their contracts gives insurers an unfair advantage in these negotiations, by eliminating key tools that can be used

to structure these agreements. Academic medical centers and teaching hospitals know best the distinct characteristics of the patient populations they serve. Consequently, they must retain flexibility to negotiate the contractual terms that best meet the needs of those patient populations.

Anti-tiering, anti-steering, and all-or-nothing clauses, at their core, protect patient access to care by ensuring a more level negotiating environment between providers and insurers. We believe these provisions strive to ensure that patients have access to in-network specialty and sub-specialty care furnished at teaching hospitals. Preventing the use of these clauses in contracts between providers and insurers will allow insurers to create networks that exclude teaching hospitals and teaching physicians, thus restricting patients' abilities to seek care at these facilities. This puts the health of patients at risk and increases costs to the patient should they seek or require out-of-network care at teaching hospitals.

Lastly, insurers routinely utilize policies and contractual provisions to exclude certain providers from their networks. Insurers oppose provisions such as "any willing provider" that would require them to include in their networks any provider willing to join their networks. Plans limit network enrollment to certain providers at teaching hospitals rather than to all providers. They vary reimbursement rates based solely on provider types or impose additional certification requirements for certain practitioners for inclusion in a network. These practices force patients to choose between paying out-of-network cost sharing to continue seeing their long-time provider or switching providers.

Issuers already require providers to comply with requirements that limit care such as prior authorization for certain items and services, or institute mid-year drug formulary changes that force patients to choose between paying more for a drug they have been taking for decades or switching to another drug. Forcing patients to upend prescription drug regimens could lead to poor health outcomes and costly treatments, including hospitalization. Plans defend these practices through assertions that they reduce health care costs to the system as a whole. However, these practices limit patient access and increase provider burden to obtain coverage for medically necessary care for their patients. Further, patients are locked into a plan for a year leaving them little recourse against mid-year coverage changes.

TIME AND DISTANCE CRITERIA

County-Specific Time and Distance Standards Are Needed to Improve Patients' Access to Providers

The AAMC supports CMS's proposal to adopt county-specific time and distance standards to assess whether QHPs offered through the FFEs fulfill network adequacy standards applicable to plans that use provider networks and to broaden the number of specialties included in the standards. The proposal includes adding specialties – emergency medicine, outpatient clinical behavioral health, pediatric primary care, and urgent care – to the time and distance requirements that are in place for Medicare Advantage plans. (p. 681). Continuity of care is often compromised due to lack of accessible providers, particularly in areas that struggle with

physician shortages. Compounding this problem, is the distance patients must travel in order to seek care from specialists who are usually located at academic medical centers.

ESSENTIAL COMMUNITY PROVIDERS

Increasing the Percentage of Essential Community Providers Will Improve Network Adequacy

The AAMC supports the proposal to increase the required percentage of essential community providers (ECPs) for medical QHP certification. ECPs include hospitals and providers that serve predominantly low-income and medically underserved individuals. Under the proposal, a plan would satisfy the regulatory standard if the issuer contracts with at least 35 percent of available ECPs in the plan's service area to participate in the plan's provider network. (p. 685). The current standard is 20 percent of available ECPs.

Academic medical centers serve as the backbone of many communities' health care infrastructure. Major teaching hospitals and physician faculty practices serve a disproportionately large volume of underserved, low-income individuals, provide access to essential health services for disadvantaged groups, and are often the last resort for treatment for many. However, in past years, QHP plan issuers have been allowed to exclude these institutions from their networks putting pressure on patients to sever ties with providers with whom they have established doctor-patient relationships or incur financially burdensome cost sharing in order to maintain continuity of care. Additionally, teaching hospitals play an important role in patient transfers. These institutions and their associated physicians have expertise and resources often unavailable at other sites of care. Excluding them from networks jeopardizes care for patients needing specialized care because relationships are not there.

TELEHEALTH

Expansion of Telehealth Services Should Not be a Substitute for In-person Services

CMS is proposing to require all issuers seeking certification of plans to be offered as QHPs through the FFEs to submit information about the use of telehealth services by network providers. Telehealth services would not be counted in place of in-person service access for the purpose of network adequacy standards. This would be applicable for QHP certification for plan year 2023. This information collected would be used to inform future telehealth standards issued by CMS. (p. 684). The AAMC supports the expanded use of telehealth services and agrees with CMS that availability of telehealth services should not be a substitute for in-person service access for the purpose of network adequacy standards.

Telehealth provides both patients and providers with benefits and expands access to care, especially to those in rural and underserved areas. The waivers put in place by CMS during the current public health emergency (PHE) allowed health care providers to quickly transition to using telehealth services to furnish needed care. This expanded use of telehealth services has enabled providers to maintain continuity of care and reach patients who may have difficulty accessing needed care during the PHE.

The Association is supportive of the expansion of telehealth services by plans to better serve their enrollees. This will allow patients to access needed specialty and sub-specialty care from AAMC-member providers. However, we believe it would be premature to provide time and distance credit for telehealth services at this time. The COVID-19 public health emergency has shown that optimal medical care for some conditions must be provided in a face-to-face encounter. Further, there are still barriers to the use of telehealth, such as the availability of broadband and access to the required equipment. As CMS formulates QHP telehealth standards to ensure that patients can continue to have access to telehealth services beyond the pandemic, legislative and regulatory changes must include the following:

- Permanently removing patient location and rural site requirements to allow patients access to telehealth visits in any location.
- Reimbursing providers the same amount for telehealth services as in-person visits.
- Permanently allowing Medicare payment for audio-only services.
- Allowing patients to access telehealth services across state lines as appropriate.
- Improving access to broadband technology.

RISK ADJUSTMENT ISSUER DATA REQUIREMENTS

Expand Collection and Extraction of New Data Elements to Improve Risk Adjustment and Promote Health Equity

CMS proposes to collect and extract the following new data elements at the enrollee-level from plan issuers' External Data Gathering Environment (EDGE) servers through issuers' EDGE Server Enrollment Submission (ESES) files and risk adjustment recalibration enrollment files: (1) ZIP code, (2) race, (3) ethnicity, (4) subsidy indicator, and (5) Individual Coverage Health Reimbursement Arrangement (ICHRA) indicator. Specific to race and ethnicity, CMS proposes to require issuers to report these elements in accordance with 2011 HHS Data Standards,[1] which would allow HHS to better analyze more subpopulations due to more granular data collection. CMS believes that collecting and extracting these data elements would allow the agency to assess and analyze risk and determine if any refinements to the risk adjustment methodology or other HHS individual or small group market programs are needed. It would also support HHS analysis and assessment of equity in health coverage and care more than current data allow. **The AAMC supports the proposed expanded data collection and extraction and agrees that the additional data could be used to improve risk adjustment and promote equity in health insurance coverage.**

In describing the potential burden of this proposal, CMS notes that issuers can report "unknown" for race and ethnicity, in alignment with application and enrollment forms so that they would not be penalized if they did not have this data for a particular plan enrollee. There is a growing consensus acknowledging the need to improve data collection for health equity, starting with collecting self-reported race and ethnicity data from individuals. Collecting such data requires

[1] 87 *Fed. Reg.* 584 (January 5, 2022) at 628, citing October 30, 2011 HHS Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status.

trust from individuals that the data will not be used against them or for discriminatory purposes. **We ask CMS to consider using "not reported/disclosed" rather than "unknown," to more precisely capture individual choice not to share information with the plan issuer and commit to studying whether there are outlier issuers for whom this data is not routinely shared.**

The AAMC also recommends that CMS consider future collection and extraction of additional data elements to expand support for health equity and address health disparities. The Administration's COVID-19 Health Equity Task Force has recently recommended the need to support equity-centered data collection,[2] specifically citing populations not routinely captured in current data collection efforts such as sexual orientation and gender identity (SOGI) and disability status. The report also notes veterans as another marginalized group, and whose status might not otherwise be captured elsewhere in claims. Currently, issuers must collect and extract enrollee "gender" though it is not clear whether this represents collection of biological sex or gender identity. Issuers are not required to collect and extract data regarding sexual orientation, disability status, or veteran status. **Considering the Task Force's recommendations for equity-centered data collection, the AAMC recommends CMS evaluate the potential benefits and burden of collecting enrollee self-reported SOGI, disability status, and veteran status data.**

Consider Ways to Include ZIP Code Data in Limited Data Set for Qualified Researchers in Order to Improve Data Available for Health Equity Research

CMS proposes to exclude ZIP codes from the limited data set for qualified researchers to request for research purposes. The agency acknowledges that while such data would "enhance the usefulness of the limited data set," it believes that it would raise competitive and proprietary concerns with the inclusion of geographic identifiers. While we understand the market competition concerns of including ZIP codes in the limited data set, the AAMC hopes CMS will consider whether there is a middle ground approach that opens the ZIP code data for health equity research in particular. This is because we believe that community-based health equity research can help inform potential interventions beyond the individual. For example, research[3] shows that community-defined social risk factors cause substantial shifts in projected performance on the Readmission Reduction Program's readmission models above and beyond individual level proxies. A clear benefit of community-based analysis compared to individual-level analysis is the reduced risk of compromising individual privacy in addition to ensuring the use of holistic approaches to broad, structural inequities. **To this end, the AAMC asks CMS to evaluate the opportunity to include the ZIP code data in some protected capacity to allow**

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[2] *See* Presidential COVID-19 Health Equity Task Force Final Report and Recommendations (October 2021), at 35 specifically **Recommendation 13. Support equity-centered data collection**, which states "The Federal Government should fund an equity-centered approach to data collection, including ensuring sufficient funding to collect data for groups that are often left out of data collection (e.g., people with disabilities, those in congregate settings, LGBTQIA+ people, etc.)."

[3] Baker et al., Health Affairs Vol. 40, No. 4, "Social Determinants Matter for Hospital Readmission Policy: Insights From New York City," (April 2021).

its use by qualified researchers engaged in health equity research or to commit to an agency study of geographic identifiers and health equity.

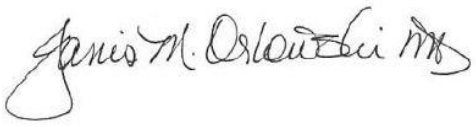
Encourage the Use of Z-Codes by Committing to Studying Their Potential Future Inclusion in the HHS-operated Risk Adjustment Program

CMS seeks feedback on potential policies that would encourage the use of ICD-10 z-codes for capturing patient and enrollee's health-related social needs. The agency notes that there are reports of inconsistent use of these codes by providers, and that more consistent use could help further assess risk. The AAMC supports efforts to improve data collection, especially data that improves our understanding of health-related social needs. Many AAMC member teaching hospitals and health systems use electronic health records (EHR)-based social risk screening tools in data collection to be better informed about the broader unmet health-related social need in their communities. We believe there is great promise in the potential of z-codes as a tool to translate data collected through screening tools in order to provide interoperable, actionable data to inform potential interventions. In order to test the promise of z-codes, we believe CMS can use its various policy levers to encourage their use. One opportunity to do so would be to commit to studying the potential inclusion of z-codes in the HHS-operated risk adjustment program. Another opportunity would be to study the inclusion of a subset of z-codes for a population to determine its usefulness. If payers and providers alike believe that z-codes will be used to inform meaningful innovations in risk adjustment, they will be more likely to commit to their use. **The AAMC believes that patients, payers, and providers will all benefit from partnership to improve health equity. CMS should lead the effort to demonstrate the benefit of better data to inform solutions.**

CONCLUSION

Thank you for the opportunity to comment on this proposed rule. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic medicine community. If you have questions regarding our comments, please feel free to contact Mary Mullaney at mmullaney@aamc.org.

Sincerely,



Janis M. Orlowski, M.D., M.A.C.P.
Chief, Health Care Officer

cc: Ivy Baer, AAMC