

September 28, 2011



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Donald Berwick, MD  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9989-P  
Room 445-G  
Hubert H. Humphrey Building  
200 Independence Avenue SW  
Washington, DC 20201

Submitted electronically at Regulations.gov

Subject: CMS-9989-P, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans.

Dear Dr. Berwick,

The American Optometric Association (AOA) submits these comments in response to the request for feedback made by the Centers for Medicare & Medicaid Services (CMS) on proposed regulations for the establishment of exchanges and qualified health plans (QHPs) as a result of passage of the Patient Protection and Affordable Care Act (ACA) of 2010.

The AOA represents approximately 36,000 doctors of optometry, optometry students and paraoptometric assistants and technicians. Optometrists serve patients in nearly 6,500 communities across the country, and in 3,500 of those communities are the only eye doctors. Doctors of optometry provide more than two-thirds of all primary eye and vision health care in the United States. Optometrists will play a valuable role in delivering care for those who are newly enrolled in QHPs. The AOA's comments are based on various stakeholder meetings that optometrists have participated in at the state level and we believe that these regulations should promote patient access to high quality community based providers – like optometrists – and ensure their access to eye and vision care.

The AOA will be commenting on the following sections of the proposed rule:

- Section 155.110 – Entities Eligible to Carry Out Exchange Functions
- Section 155.130 – Stakeholder Consultation
- Section 155.1050 – Establishment of Exchange Network Adequacy Standards
- Section 155.1065 – Stand-Alone Dental Plans
- Section 156.200 – QHP Issuer Participation Standards
- Section 156.230 – Network Adequacy Standards
- Section 156.235 – Essential Community Providers
- Section 156.245 – Treatment of Direct Primary Care Medical Homes

## **Section 155.110 – Entities Eligible to Carry Out Exchange Functions**

The AOA applauds CMS for proposing standards for entities that can carry out the exchange functions and for exchange governing boards to include members that have a basic level of understanding of the complexities of the healthcare market. Those members would be in a better position to properly advocate for the consumers in the exchange governance structure. We have a few comments about specific sections within the proposed regulations that we feel would enhance the exchange governance structure.

In paragraph (c)(2) CMS recommends that exchanges hold regular public governing board meetings that are announced in advance. Ideally, the exchanges, regardless of their affiliation with the state as either a state entity or a private entity would be subject to a state's sunshine or open meetings act which would require advanced notice of meetings. CMS may want to consider making adherence to an open meetings act as part of the exchange certification process. If CMS feels that the statement in the current regulations is strong enough to compel open meetings, then CMS may wish to consider mandating that the exchange governing board meet at least once a year, similar to the requirements on non-profit organizations in order to facilitate public input in the exchange governance.

In paragraph (c)(3), CMS should consider stronger conflict of interest standards that would ensure that those who serve on the governing board are free of any compromising conflicts. The AOA suggests that any member of the governing board should have to file a conflict of interest statement with the exchange and disclose any fiduciary interests that a person may have in a health insurance issuer, agent or broker. However, when a board member is a healthcare provider who is credentialed to provide services on a particular QHP this should NOT be considered a conflict per se unless that QHP makes up a substantial percentage of their practice.

Finally, in paragraph (c)(4), CMS establishes categories of experience for voting board members and asks for comments on the "types of representatives that should be on exchange governing boards to ensure that consumer interests are well-represented and that the Exchange board as a whole has the necessary technical expertise to ensure successful operations." The AOA applauds CMS for including several groups that have expertise in healthcare administration; however, permitting providers on the governing board can bring a prospective that would benefit consumers and purchasers by ensuring that providers are fairly treated by the QHPs that are certified to participate in the exchange. When including providers as a category, CMS should specify that states should include not just Medical Doctors (MD) and Doctors of Osteopathy (DO) but other types of providers like optometrists as well. Having other community based providers will ensure that consumer access to these providers will be protected within the Exchange market place and provide feedback to the Exchange governance structure beyond that of MDs and DOs. As CMS is well aware, in Massachusetts where many of the proposals contained within the ACA are already law, many patients have seen longer waits to see primary care physicians. While this may be because of a lack of primary care providers, it is also due to discriminatory credentialing practices by QHPs that are not permitting non-MD/DO providers to offer primary care services within their scope of practice. Optometrists are frontline primary care providers who provide critical diagnosis and treatment of eye diseases as well as early intervention in diseases such as diabetes and hypertension which will ensure that these chronic diseases are treated early and therefore more cost effectively. Having other community based providers like optometrists can assure that QHPs are

meeting their primary care adequacy requirements by giving feedback on their experiences out in the community on a regular basis ensuring that there will not be access issues such as those faced in Massachusetts.

### **Section 155.130 – Stakeholder Consultation**

The AOA agrees with CMS that the list of key stakeholders is more broad than the list included in the Section 1311(d)(6) of the ACA. The ACA requires HHS to “engage in consultation to ensure a balanced representation among interested parties.” CMS should hold entities carrying out exchange functions to the same standard. The AOA strongly supports the CMS proposal to require that the Exchange must “regularly consult on an ongoing basis with the following stakeholders” including health care providers. Further, CMS should ensure that all providers are adequately represented. For example, MD/DO representatives typically sought for consultation do not speak for the entire provider community nor should they be able to represent themselves as such. Other physicians, such as optometrists, and health care professionals who do not hold an MD or DO degrees should be represented. The AOA suggests that all health care providers that provide services to beneficiaries in QHPs should have an opportunity to give feedback to the Exchange governance and this needs to be reflected in the regulations. We recommend that Section 155.130(h) read:

(h) all health care providers who offer services to QHPs beneficiaries without regard to type of license.

### **Section 155.1050 – Establishment of Exchange Network Adequacy Standards**

The AOA strongly supports QHP adequacy standards that strongly protect patient access to high quality eye and vision care such as that offered by optometrists and while the initial proposal offered by CMS in Section 155.1050 meets the wording of the ACA, CMS can and should go a lot further to ensure that exchanges meet patient expectations when it comes to provider access. The AOA understands the goal of ensuring flexibility for the states setting up the exchange, however, the public will have an expectation that there will be enough providers to meet their needs when signing up for an exchange plan. CMS can meet those expectations by ensuring that states have strong adequacy standards required by CMS regulation and not left up to too much state interpretation. These standards should be nondiscriminatory against classes of providers and ensure that patients can access needed medical services regardless of the provider type. At the same time, CMS should protect a state’s right to impose stricter adequacy standards than what CMS has proposed. The ACA already sets a precedent for provider nondiscrimination in Title I, Section 1201 which reads as follows:

“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.” 42 U.S.C. §300gg-5(a).

This particular language is directed towards prohibiting QHPs and non-exchange group health plans and individual plans from discriminating against any health care provider who is acting within the scope of that provider's license or certification under applicable state law. This provision increases choice and access for patients by preventing plans from arbitrarily eliminating access to licensed practitioners based solely on their professional degree and not based on their abilities. By increasing the pool of potential network participants these non-discrimination provisions provide patients with more choices by increasing market competition among providers. Competition will incentivize all practitioners to further improve the quality and cost of the services they provide in order to be a more attractive option for the patient. This language should be the basis of a standard of network adequacy that could protect patient access to high quality providers. The AOA believes access to care, particularly primary eye care, and nondiscrimination are key components for CMS to meet its objectives to protect consumers, to provide some consistency across state lines, and to allow states adequate flexibility to meet local needs. Therefore, the AOA would propose that CMS adopt the following language in regulations for network adequacy (amendments in *italics*):

§155.1050 Establishment of Exchange network adequacy standards.

*“An Exchange must ensure that the provider network of each QHP offers a sufficient choice of providers for enrollees and that each QHP must certify that the panel of providers meets the requirements of 42 U.S.C. §300gg-5(a) of the Public Health Act as amended by Title I, Section 1201 of the Patient Protection and Affordable Care Act.”*

Additionally, CMS has asked for comments on “additional minimum qualitative or quantitative standards for the Exchange to use in evaluating whether the QHP provider networks provide sufficient access to care.” As part of those standards, CMS has proposed four more specific standards based on the National Association of Insurance Commissioners (NAIC) Managed Care Plan Network Adequacy Model Act and typical language used by states, Medicare Advantage, TRICARE Prime and Medicaid managed care plans.

While the proposed language would require: sufficient numbers and types of providers that would prohibit delay of treatment, providers are of a reasonable proximity to network enrollees; an ongoing monitoring process to ensure sufficiency of access by enrollees; and a process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if there are no timely in-network providers will help enrollees receive the care they paid for. Without strong anti-discrimination requirements, patients will still be prevented from receiving care from providers if QHPs are not prohibited from discriminating. Optometrists are regularly the victims of health plans that discriminate against non-MD physician providers and deny patient access to high quality eye and vision care. That discrimination is not limited to commercial carriers but also to the carriers who work with the Medicare, TRICARE and Medicaid programs cited by CMS as the basis of these standards. If CMS is to truly ensure access to care for enrollees in QHPs then it must include protections for providers to fight

back against the discrimination. The AOA strongly urges CMS to adopt language similar to our suggested amendment to Section 155.1050 above to the list of specific standards CMS is considering.

Finally, CMS recognizes that primary care access is a challenge in many communities nationally and will be exacerbated by ACA requirements that go into effect in 2014 and is considering adequacy requirements that would protect primary care services for beneficiaries. The AOA applauds this proposal and strongly encourages CMS to include this provision in the final regulations on exchanges. However, if CMS is going to (or recommend to states) broadly define types of providers that furnish primary care services the AOA encourages CMS to include optometrists as one of those providers. Primary eye and vision services, such as the ones provided by optometry, ensure early diagnosis and treatment of chronic diseases such as hypertension, diabetes, glaucoma, age-related macular degeneration and cataracts which when treated early enough are highly manageable in a more cost effective manner. The highly integrative sensory and motor functions inherent in the visual system also put optometrists at the forefront of diagnosing many acute intracranial neurological diseases such as stroke. In addition, as a community based providers, optometrists, who serve patients in nearly 6,500 communities across the country and in 3,500 of those communities are the only eye doctors, will typically be one of the first healthcare providers many patients come into contact with and are a necessary piece of comprehensive primary care delivery in the US. CMS should include optometrists in any list of primary care providers that it establishes for these regulations.

By utilizing community based providers like optometrists in QHPs in the exchange, the community will financially benefit through indirect cost savings in travel expenses not having to travel further within or outside of the consumer's community and the benefits of spending less time away from work for either the consumer or their responsible care giver to travel further for care. Also, cost savings in disease morbidity result from more expedient access to care locally obtained from a provider they are already accustomed to accessing for services. In addition, allowing patients to access their optometrists those patients who are already accessing optometric services will be billed on an "established patient" basis as opposed to a higher "new patient" rate with a new provider.

#### **Section 155.1065 – Stand-Alone Dental Plans**

The AOA applauds CMS on the proposed regulations for stand-alone dental plans that wish to become QHPs in the Exchange and strongly encourage CMS to keep the standards as proposed in order to protect the public who are purchasing dental coverage. Additionally, CMS has asked for comments if stand-alone dental plans should have to comply with the "QHP certification requirements and consumer protections." The AOA believes that in fairness to other QHPs subject to certification and consumer protections and in order to protect the public, CMS should subject stand-alone dental plans to the same rules as other QHPs especially the requirements of Title I, Section 1201 of the ACA. This will ensure that all QHPs are operating at a fair and equitable level for patients and providers.

Congress intended the exchanges to be markets for consumers to obtain health insurance that would cover benefits deemed "essential." In its wisdom, Congress decided to specifically allow standalone dental plans to also participate directly in the exchange. The law does not allow for any other type of standalone plan to be marketed in the exchanges. CMS should require standalone dental plans to meet all of the requirements for qualified health plans except for coverage of essential benefits other than

oral health care. In addition, to prevent re-fracturing health care delivery into silos, CMS should not require essential oral health care benefits be priced separately.

### **Section 156.200 – QHP Issuer Participation Standards**

The AOA supports CMS' proposal to require insurance issuers to receive a certification by the Exchange in order to be a QHPs and believes that this is an important provision to ensure public confidence in the QHPs being offered in the exchange. The AOA suggests that CMS amend §156.220(b) and require QHPs to certify that they are in compliance with Federal law and regulations as passed under the ACA Title IX, Subsection B, Section 2301 and Title I, Section 1201. This will ensure that all non-grandfathered health plans are on the public record as stating that they are in full compliance with the ACA and make noncompliance with this provision a serious enough offense that it would jeopardize a QHP's ability to offer services in the exchange. CMS may wish to set various levels for not complying with the ACA insurance provisions in order to avoid accidental violations of the provisions and allow the punishment for willful violations of the ACA.

The AOA also comments on §156.220(b)(4) where a QHP must certify that it is in "good standing" to offer health insurance in the state. While CMS is interpreting this standard to mean that there are no outstanding sanctions imposed by a state's insurance department, this definition could also mean that a health insurer has a document from the state permitting it to offer health insurance products within the state. The AOA believes that CMS should adopt a wider definition of "good standing" which will be another tool to protect patients from bad actors in the insurance market. The AOA would propose that this certification from the state should not only show that QHPs are not being sanctioned by state law but should also include an affirmative statement that the plan is in total compliance with state law. This, like the suggested amendment to certify plans are in compliance with Federal law, will demonstrate to the public that all QHPs are complying with current state law and give the public the confidence that they are doing business with an insurer that is in full compliance.

### **Section 156.230 – Network Adequacy Standards**

The network adequacy standards that CMS proposes in this Section are a good starting point and will assist consumers in finding providers necessary to receive the treatment they need. CMS should go one step further and incorporate the adequacy standards proposed in Section 155.1050 and directly reference the exchange adequacy standards as they would apply to QHPs, including directly referencing the important insurance reforms passed in the ACA. What appears to be redundant is another tool that the Exchange can use to install consumer confidence in the product and the protections afforded under the ACA with little additional burden on insurers.

CMS asks for comments on what standards should be adopted to "ensure that QHP issuers maintain up-to-date provider directories." The AOA believes that whatever standard CMS chooses to adopt, there should be minimal burdens on providers when QHPs are gathering this information. In addition, there needs to be an easily accessible method for providers to amend directory listings and this directory in no way is used as a tool to discriminate against types of providers by not properly reflecting their title, level of education and full scope of practice as authorized by the state in which the exchange resides. These

protections will safeguard patients' ability to access appropriate providers for their needs and that the directories are not misleading as to the scope of practice of a particular provider.

Finally, the AOA recommends to CMS that all QHPs be required to report on their adherence to the adequacy standards established by this rule as a condition for participation in the exchange. CMS has made a similar proposal for Medicaid plans in proposed rule "CMS 2328-P Medicaid Program; Methods for Assuring Access to Covered Medicaid Services," that would change § 447.204 to require states to publically demonstrate that the rate changes they are making will not adversely affect patient access to providers. A similar proposal for QHPs will safeguard patient access and ensure that providers are well represented on plan networks.

### **Section 156.235 – Essential Community Providers**

The AOA believes that CMS has wide discretion when defining essential community providers and we suggest that CMS use as broad of a definition as possible. The ACA states in section 1311(c)(1)(C) that QHPs should:

(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111–8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;

This definition does set up a limited definition of essential community providers, but we feel the intent of the ACA to ensure as many people in the community as possible have access to all types of primary care and would consider other providers beyond those described above as essential community providers. CMS should create a definition that properly reflects the expectations of the population wherein a provider within a medically underserved area providing the services should be covered under the essential community provider definition. The AOA recommends that CMS use the same definition that the Health Resource and Services Administration (HRSA) uses to determine which providers are legally permitted to offer basic health services in a Federally Qualified Health Center (FQHC) as defined in 42 USCS § 254b(2)(b)(1)(A)(i). Since the medically underserved population is already serviced by FQHC it would make sense to have that population to continue to see the same community based providers when they receive coverage through a QHP. Optometrists, for example, have been diagnosing and treating eye disease in the population for years and partner with FQHCs throughout the country providing critical diagnosis and treatment of eye diseases as well as early intervention in diseases like diabetes and hypertension. Providers who work in FQHC would be an excellent standard to use as essential community providers especially since they have already showing a willingness to work in medically underserved areas.

CMS is also looking for comments about how to determine a "sufficient" number of essential community providers on a QHP. The AOA would recommend that using the three definitions --Public Health Service Act definition, the Social Security Act definition and FQHC providers -- and offer "any willing essential provider" who wants to accept the QHP terms on the panel. Higher paying commercial QHPs may entice

additional providers to offer their services within a medically underserved area and allowing greater access to a plan for providers who do not typically have access to commercial insurance plans will be a recruiting tool for providers who will help cover this underserved population.

Finally, QHPs should be prohibited from discriminating against essential community providers by varying payment based on the type of provider as prohibited by Title I, Section 1201 of the ACA. This should also extend to FQHC and Indian health service providers that qualify as essential community providers.

#### **Section 156.245 – Treatment of Direct Primary Care Medical Homes**

The Primary Care Medical Home is a tool used by primary healthcare providers to better manage the care of patients by having one entity help direct a consumer's use of healthcare, thus bringing down long term costs and improving outcomes. Optometrists are willing and able to be full partners with other healthcare providers to ensure the success of the Primary Care Medical Homes (PCMH). The AOA believes that CMS should establish a certification process for medical homes to be eligible to contract with QHPs that should be administered through the state Exchange. This would create a centralized organization within the state that would track and monitor medical homes. In addition, the states should use standards for medical homes similar to those developed by the National Committee for Quality Assurance and other national associations and certify to the state that PCMH are not discriminating against types of providers. Finally, to ensure high quality care for enrollees in a PCMH the exchange should require that the PCMH's must publically report quality measures in order to be certified to participate in the Exchange. An example of the type of information that should be reported to the public is a documented annual eye exam for patients who have diabetes. This measure is a documented indicator of quality diabetic patient care and would help inform the public that a PCMH is providing the necessary care to patients so they may make an informed decision about which PCMH they should participate in.

In conclusion, on behalf of our membership and the millions of beneficiaries that our members serve, we thank CMS for considering these comments and using the feedback to ensure that exchanges are successfully executed and QHPs fairly work with optometrists. Please contact Brian Reuwer, Associate Director for Advocacy and Affiliate Relations at [breuwer@aoa.org](mailto:breuwer@aoa.org) or (703) 837-1343 if you have questions or need additional information about these comments.

Sincerely,



Dori Carlson, OD  
President