TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

December 23, 2013

Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-9945-IFC
Mail Stop C4-26-05
Security Boulevard
Baltimore, MD 21244-1850

Re: *Comments on "Patient Protection and Affordable Care Act; Maximizing January 1, 2014 Coverage Opportunities" Interim Final Rule (CMS-9945-IFC), as published in the Federal Register at 78 Fed. Reg. 76212 et seq. on December 17, 2013*

The Texas Medical Association ("TMA") is a private, voluntary, nonprofit association of Texas physicians and medical students. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, our maxim continues in the same direction: "Physicians Caring for Texans." TMA's diverse physician members practice in all fields of medical specialization.

TMA appreciates this opportunity to comment on the U.S. Department of Health and Human Services' ("HHS" of "Department") interim final rule published in the Federal Register on December 17, 2013. Specifically, TMA would like to take this opportunity to comment on the Department's policies regarding access to providers when consumers transition to qualified health plans ("QHP") offered through a Health Insurance Exchange ("Exchange"), as set forth in the interim final rule. TMA ***strongly opposes*** a rule or recommended policy that forces a physician[1] to operate under contractual terms he or she has not agreed to or has properly terminated. Such policies ignore the basic principles of contract law and compel physicians to incur significant expense as a result of QHP issuers' failure to maintain accurate provider directories.

I. *"Other Policies to Smooth Transition": Provider Access*

This comment letter specifically relates to Section C of the interim final rule ("Section C") regarding consumers' access to physicians and other health care providers when selecting a QHP through an Exchange.[2] In Section C, HHS acknowledges that: (1) consumers may select a QHP based, at least in part, on the physicians and other health care providers listed in an issuer's provider directory; (2) provider directories are often inaccurate, outdated, and may mislead consumers when selecting a QHP; and (3) the QHP issuer is solely responsible for the contents of its provider directory.

> "*When shopping for coverage on an Exchange, prospective enrollees may base QHP selection decisions on whether their provider is considered in-network using the issuer's online provider directory. However, evolving provider networks may result in some issuer provider directories*

[1] For the purposes of this comment letter, TMA utilizes the terms "physician" and "physicians" to include individual professionals, partnerships, and other business organizations comprised primarily of physicians.

[2] *See* 78 Fed. Reg. 76215 (Dec. 17, 2013).

> *containing outdated information. As a result, an enrollee may later discover that his or her provider is considered out-of-network. We are concerned that this could cause hardship to new QHP enrollees in the early months of coverage and could disrupt what could otherwise be a more seamless transition into a QHP. We strongly encourage QHP issuers to take any steps possible to ease this transition.*"[3]

The interim final rule highlights QHP issuers' responsibility under existing regulations to make current and accurate provider directories available to the Exchange and potential enrollees.[4] It also acknowledges the confusion and hardship that inaccurate, outdated provider directories may cause. Appropriately, the Department directs QHP issuers to prevent this foreseeable harm.

While existing regulations and the interim final rule clearly expect QHP issuers to ensure that enrollees are able to review and rely on current and accurate provider directories when selecting a QHP, the interim final rule "strongly encourages" QHP issuers to treat an out-of-network physician as "in-network" if an issuer incorrectly includes the physician in its provider directory. In other words, a physician's out-of-network status may change, without the physician's knowledge or consent, based solely on a QHP issuer's failure to maintain an accurate provider directory.[5]

> "*For those directories that cannot be maintained in a current status, we [HHS/CMS] believe that it would be reasonable for issuers to consider services received out-of-network as having been received in-network (subject to in-network coverage and cost-sharing standards) with respect to any provider listed in the version of the provider directory as of the date of that enrollee's enrollment for the beginning months of coverage. We strongly encourage issuers to adopt this approach.*"

At best, this is a puzzling proposal. QHP issuers have the access, ability, and obligation to ensure that provider directories are accurate and up-to-date. However, physicians and other health care providers may be subject to substantial consequences as a result of a QHP issuer's failure to meet this standard. The interim final rule lacks any significant incentive for a QHP issuer to fulfill its obligation to maintain an accurate directory (we are not aware of any potential penalties, sanctions, or disciplinary actions a QHP issuer may face if it fails to meet its obligation). Remarkably, the Department's misguided approach "strongly encourages" shifting risk and expense that should be assumed by QHP issuers to non-contracted physicians and other providers.

TMA is keenly aware of the increasing pressure to quickly promulgate rules intended to further facilitate enrollment in QHPs through the Exchanges. However, the interim final rule's silence regarding the potential impact this approach will have on physicians and other providers suggests an enormously unfortunate oversight or a government grab at discount health care services intended to benefit a private third party—specifically, QHP issuers. TMA strongly opposes any regulation or policy requiring a physician to comply with contractual reimbursement rates and billing procedures he or she has not agreed to or has properly terminated. The Department's approach, as expressed in the interim final rule, expects physicians and other providers to shoulder unexpected—and undeserved—financial costs and administrative burdens as a result of an unrelated third party's noncompliance. TMA asserts QHP issuers will most certainly attempt to pay less than the billed amount and improperly argue this final regulation imposes a "hold harmless" obligation upon physicians.

Physician and other provider participation in health plan networks is governed by contract. Terms are negotiated, reimbursement rates are disclosed, and procedural rights (e.g. termination and appeal) are documented in writing and agreed to by the parties. The interim final rule ignores this basic legal tenet that a contract requires an offer and acceptance. It also disregards the fact that contracts are traditionally regulated by state law. The interim final rule implies that it is reasonable—and legal—for a federal recommendation to require a physician to operate under

[3] 78 Fed. Reg. 76215 (Dec. 17, 2013).

[4] *See* 45 C.F.R. §156.230(b); 78 Fed. Reg. 76215 (Dec. 17, 2013) (stating QHP issuers should ensure that provider directories…for the QHPs on Exchanges contain the most current listing of in-network providers so that consumers can rely upon accurate information to make enrollment decisions.).

[5] 78 Fed. Reg. 76215 (Dec. 17, 2013).

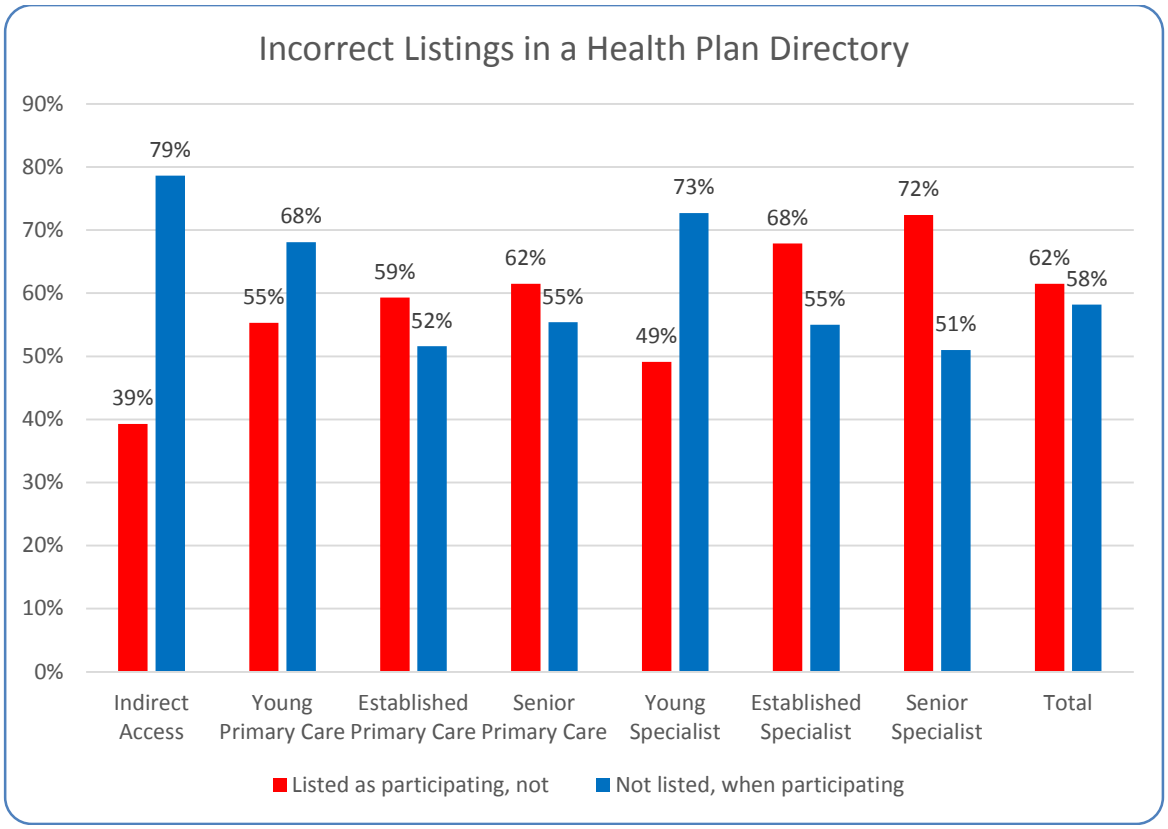
contractual terms he or she did not accept or has properly terminated. This suggests that the traditional contractual relationship between a health plan and an in-network physician be trumped by a rule of convenience. TMA ***strongly opposes*** any rule or recommendation that seeks to force a physician to operate under contractual terms he or she has not agreed to or has properly terminated.

II. *Additional Considerations*

In addition to the concerns stated above, TMA offers the following considerations regarding the proposal to treat out-of-network physicians as "in-network" based on an issuer's inaccurate provider directory.

1. *Currently, Many Health Plan Directories are Inaccurate and Outdated*

A recent survey of Texas physicians found that a majority of physicians have detected cases where they were listed incorrectly in a health plan's directory.[6] Based on TMA's 2012 survey findings, health plan directories frequently misrepresent the plan's actual network. In fact, the survey found that **62 percent of physicians had detected cases in which they were listed as participating when they were not, and 58 percent of physicians had detected cases where they were not listed when they were participating in a plan**. Notwithstanding the existing inaccuracies in health plan directories, the Department's interim final rule suggests directories like the ones referenced in this survey should determine whether or not a physician's services should be treated as "in-network" services.



[6] *See* Texas Medical Association Survey of Physicians (2012), available at: http://www.texmed.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=25268&libID=25269

2. The Interim Final Rule Provides No Incentive for QHP Issuers to Maintain Accurate Provider Directories

TMA supports the regulatory requirement for a QHP issuer to make its provider directory available to the Exchange for publication online and to potential enrollees in hard copy upon request.[7] However, there does not appear to be an incentive to comply with this rule or meaningful consequences for QHP issuers that neglect this obligation. The Department encourages QHP issuers to maintain up-to-date provider directories; however, if a QHP issuer's provider directory is not accurate, the interim final rule suggests an approach aimed at protecting the issuer from potential administrative costs and inconvenience associated with the same—despite the fact that prospective enrollees rely on this information.[8] TMA urges the Department to take meaningful steps to hold QHP issuers accountable for the contents of their provider directories.

3. Physicians Have No Recourse in Response to an Incorrect "In-Network" Designation

The interim final rule provides no guidance regarding a physician's right to appeal, terminate or remediate an incorrect "in-network" designation. In other words, if a physician has been incorrectly listed in a QHP issuer provider directory, the interim final rule offers no method of appealing the QHP issuer's error, requiring the QHP issuer to immediately correct its mistake, terminating any pseudo-contractual arrangement created under the interim final rule, or remediating associated damages. In fact, the interim final rule seems to assume that a physician that has been improperly included in a provider directory will continue to provide services under the inappropriate "in-network" designation for several months.[9] This language is incredibly broad and does not appear to place any duty or obligation on the QHP issuer to correct misrepresentations in its provider directory. This language may even be construed to imply that, in the Department's opinion, even if a QHP issuer is aware of an inaccuracy in its provider directory, an out-of-network provider may be bound to in-network rules and reimbursement for "months". Such a policy is akin to indenturing physicians to the QHP issuers as long as the issuer's provider directory is inaccurate. TMA notes that this "policy" is not captured in actual regulatory text. However, TMA asserts that the implementation of this policy by QHP issuers must be strictly scrutinized and regulated. TMA suggests the following language to ensure the duty to hold an enrollee harmless always lies with the issuer (who has voluntarily undertaken the responsibilities associated with a QHP) and is not a burden shouldered by the non-contracted physician or provider. To that end, TMA suggests the following regulatory text to be placed in regulation in a section HHS deems appropriate:

> § XXX.XXX Settlement of Certain Claims for Services Provided by Non-contracted Physicians and Providers. (a) If an enrollee obtains services from a physician or provider that is listed as an in-network or preferred provider who is not under contract with the issuer, the issuer shall fully pay the out-of-network or nonpreferred physician or provider and calculate the issuer's payment

[7] 45 C.F.R. §156.320(b).

[8] TMA notes that CMS and HHS have previously recognized the importance of a provider's contractual agreement to participate in a QHP network, stating that "a provider directory … should generally identify the services that the provider is contracted to perform" and "a provider's contracting status has significant implications for patients." *See* 77 Fed. Reg. 18420 (March 27, 2012). However, apparently, the need for, and legal significance of, a contractual arrangement between a provider and a QHP issuer may be outweighed by the potential for QHP issuers to experience administrative costs or inconvenience associated with maintaining updated provider directories. *See* 77 Fed. Reg. 18420 (March 27, 2012) ("We afford each Exchange with discretion to provide guidance to QHP issuers with respect to the updating of provider directories, including how frequently issuers must identify providers who are no longer accepting new patients. We urge Exchanges to consider the appropriate balance between supporting consumer choice and the burden on QHP issuers associated with this standard (which should be lower for electronic directories than for hard copy directories)."

[9] *See* 78 Fed. Reg. 76215 ("For those directories that cannot be maintained in a current status, we [HHS/CMS] believe that it would be reasonable for issuers to consider services received out-of-network as having been received in-network (subject to in-network coverage and cost-sharing standards) with respect to any provider listed in the version of the provider directory as of the date of that enrollee's enrollment for the beginning months of coverage.").

and the enrollee's financial responsibility for services on the amount submitted on the claim as the out-of-network or nonpreferred physician's or provider's billed charge.

4. Physicians Believe Patients in New Plans Must Not be Subject to Disruption of Care.

TMA shares the HHS concern that patients who have chosen new coverage because their previous coverage was canceled or the patient has voluntarily undertaken the purchase of a QHP may suffer from a disruption in coverage due to differences in network composition. Again, this is merely a statement of policy and encouragement and appears to be related to the inaccuracy of QHP provider directories. If that is the case, the proposed policy is too narrow. Furthermore, the implementation of this policy is the keystone of its possible success, yet there is no regulatory text against which QHP issuer behavior is held.

TMA suggests the following regulatory text to be placed in regulation in a section HHS deems appropriate:

> § XXX.XXX. Protection of Enrollees of Special Circumstance. (a) "Special circumstances" means a condition regarding which the treating physician or health care provider reasonably believes that discontinuing care by the treating physician or provider could cause harm to the enrollee. Examples of an enrollee who has a special circumstance include an enrollee with a disability, acute condition, or life-threatening illness or an enrollee who is past the 24th week of pregnancy.
>
> (b) The treating physician or health care provider may request, in writing, that the enrollee be permitted to continue treatment under the physician's or provider's care, and the QHP issuer shall fully pay an out-of-network or nonpreferred physician or provider and calculate the issuer's payment and the enrollee's financial responsibility for services on the amount submitted on the claim as the out-of-network or nonpreferred physician's or provider's billed charge.
>
> (c) Notwithstanding subsection (b), an enrollee's financial responsibility may not exceed the amount the enrollee would have paid if the physician or provider was in-network or preferred. The QHP shall pay an amount necessary to ensure all medical debt associated with the treatment of the enrollee under this section is fully discharged.

III. *Conclusion*

TMA urges the Department to take meaningful steps to protect physicians and other providers from the potential consequences that may result from the "smooth transition" policies suggested in the interim final rule. Only QHP issuers have the access, ability, and obligation to ensure that provider directories are accurate and up-to-date. Accordingly, TMA strongly encourages the Department to hold QHP issuers—not out-of-network physicians and other providers—responsible for maintaining accurate and current directories. Similarly, QHP issuers—not out-of-network physicians or other providers—should shoulder the burden (and expense) when issuers' provider directories misrepresent participating physicians and mislead prospective enrollees. To that end, we encourage the Department to institute policies and impose regulations requiring QHP issuers to hold harmless enrollees that reasonably rely on the issuer's inaccurate provider directory and fully discharge any debt the enrollee incurs related to services the enrollee receives from an out-of-network physician incorrectly designated as "in-network". Furthermore, to ensure this policy is appropriately executed by QHP issuers, we urge the Department to require QHPs to pay the billed charges of any out-of-network physician that was inaccurately listed in the QHP issuer's provider directory while providing services to a QHP enrollee. Again, only QHP issuers have the access, ability, and obligation to ensure that provider directories are accurate and up-to-date and the issuers must be held accountable for such misrepresentations. Absent such policies or regulations, it is difficult to see how the Department's proposal in the interim final rule does not constitute government taking intended to convey a benefit (a contractual right that does not exist) to a private party (QHP issuers). TMA ***strongly opposes*** the financing of QHP coverage on the backs of physicians.

Once again, TMA thanks you for the opportunity to provide these comments. If you should have any questions or need any additional information, please do not hesitate to contact TMA at 512-370-1300.

Sincerely,

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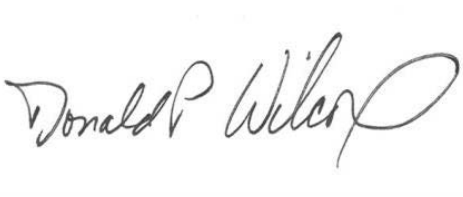

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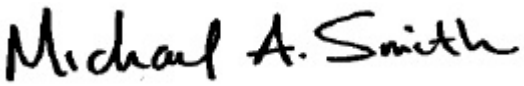

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