



June 9, 2014

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9942-NC
P.O. Box 8016
Baltimore, Maryland 21244-8016

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

The American Chiropractic Association (ACA) is the largest professional association in the United States representing over 130,000 doctors of chiropractic (DCs), chiropractic assistants (CAs) and chiropractic students. ACA promotes the highest standards of ethics and patient care, contributing to the health and well-being of over an estimated 27 million individuals across the United States. The ACA appreciates the opportunity to provide comments on CMS-9942-NC, Request for Information Regarding Provider Non-Discrimination.

Why Provider Non-Discrimination in Health Care is Essential:

Discrimination against any provider group, as a whole, is harmful to patients and restricts the patient's ability to select the provider of their choice. Health plan discrimination is not only wrong in principle, but is without justification based on the universal benchmarks of quality of health care. In today's delivery system, health plans routinely discriminate against whole classes of healthcare non-MD/DO providers based solely on their type of licensure or certification. Discrimination against the inclusion of non-MD/DO providers in health plans is clearly anti-competitive in nature, widens the provider workforce gap, and denies patient choice and access to a wide range of qualified providers. Simply put, limiting a patient's access of services in a health plan simply because of the type of health care provider chosen results in a restrictive less than optimal plan in that the number of treatment options, frequently provided at lower costs, are often minimal or eliminated entirely for one provider type and not another. This has occurred with respect to the availability of the services provided under multiple commercial third party payers including Medicare and Medicaid, where access and coverage of the conservative care first approach of chiropractic physicians is extremely limited.

Discrimination of this nature not only places unnecessary burdens on patients but inhibits best practices, data collection on outcomes and innovation in health care that may lead to lower costs. In certain underserved areas and financial situations it may result in no essential health care delivered at all.

Examples of Provider Discrimination Against the Chiropractic Profession and Chiropractic Patients:

Self-insured plans have developed benefit structures wherein there is a chiropractic/spinal manipulation benefit; however, the benefit is only payable when the services are rendered by a Medical Doctor (MD) or Doctor of Osteopathy (DO), but not by a Doctor of Chiropractic (DC). This effectively creates an illusory benefit and drives patients away from choosing a DC for their care, and away from chiropractic treatment and spinal manipulation due to the scarcity of MD/DOs who will perform manipulation.

There are a growing number of major carriers that have enlisted chiropractic or physical medicine networks to administer chiropractic benefits for their enrollees. This approach, ostensibly to manage costs in some respects, has rather, in reality, created a new and reduced “benefit package” developed by the network irrespective of state scope of practice laws and regulations. This reduced benefit package for only certain provider types has placed an unnecessary and unfair burden on patients. There are some cases where the carriers and networks offer coverage for certain procedures for one provider type but not others even though they are fully trained and licensed to perform such procedures. This scenario is confusing to patients who are somehow expected to understand that some insurers cover all procedures allowed by state and federal law but others are not required to do so. Adding to the confusion is the fact that this discriminatory limited benefit is not revealed in the patient’s health insurance contract. Rather, it is only found in the provider agreements, not easily available to be reviewed by a patient. Examples of provider discrimination that directly impact patients’ access, coverage and reimbursement are:

- Limited number of visits per year as compared to other provider types regardless of medical necessity and appropriateness of care.
- Limited or no coverage for certain services/procedures regularly provided by DCs. Among them are physical therapy or physical medicine services routinely covered without restrictions by other providers but not for DCs.
- Caps or barriers on the number of examinations per condition or year regardless of medical necessity.
- Inability to order or perform certain diagnostic tests when medically necessary.
- Limited coverage for certain diagnosis codes regardless of state scope of practice laws.
- Little or no coverage for wellness and preventive screenings even when allowed within a DC’s state scope of practice.
- Limited or no coverage for Durable Medical Equipment (DME) products and services when medically necessary and appropriate and allowed by other provider types.
- Limited acceptance of a DC determination of patient disability status.

In addition, these networks have also been found to alter Explanation of Benefits (EOBs) that have the effect of misrepresenting to the enrollees the amount they owe for health care services and the amount that the provider was actually paid, leading to greater out-of-pocket costs (because the patient’s co-pays are calculated off inflated amounts). This also interferes with the doctor-patient relationship because these networks and payers misclassify the administrative fee owed to the network as a *medical cost*.

This practice may, in effect, be allowing the carrier to report an inaccurate Medical Loss Ratio (MLR). The MLR represents the percentage of premium income that a carrier pays out in medical expenses on behalf of subscribers, as compared to the portion spent toward administrative costs. Under the new federal health care law, the Patient Protection and Affordable Care Act (PPACA), carriers are required to meet certain MLR requirements in order to avoid paying back rebates of excessive premiums to subscribers. Through the actions described, the carriers are presumably able to misrepresent the administrative fee as a medical expense, thereby minimizing the potential for paying rebates under PPACA. Some networks apply an administrative fee as high as 30 percent, at times exceeding the actual payment amount on the claim.

ACA has received reports from providers who, as a result of PPACA, have been relegated to benefit levels with inordinately high deductible and co-pay levels that result in driving patients away from treatment by DCs and toward more costly forms of care.

The services provided by DCs often involve physical therapy modalities. Under a major federal plan, a recent change expanding the benefit for chiropractic care took place reported to be in keeping with Sect. 2706(a). The plan stated that, *"We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a physician, a physical therapist, or an outpatient facility."* Differences in payment that exist simply due to format of reimbursement (e.g. Diagnosis Related Group (DRG) vs. fee for service) are understandable, but the same service being reimbursed differently between provider types in similar settings is inappropriate.

Payers are changing policies to bundle services in preparation for moving away from fee for service; however, rather than create a *combined fee*, they simply eliminate one fee and pay for the other. This is not in keeping with the calculation of relative values. In other words, chiropractic manipulative treatment (CMT) may be bundled with manual therapy as a result of PPACA, and providers have been notified that no reimbursement will be made for manual therapy whatsoever when these services are performed together, regardless of the modifier used. These types of limitations are not applied to other provider types.

Background on Section 2706 (a):

In passing PPACA, Congress enacted provisions intended to ensure patient choice of provider and prevent discrimination against entire classes of health care providers by health insurance plans. As we go about the critically important task of implementing the changes to our nation's health delivery system, we believe it extremely important to ensure that any regulations, guidance, statements or interpretations reflect those patient and provider safeguards, which are historically based in state law.

All fifty states have enacted patient and consumer protections, along with insurance guarantees, that apply to the portion of the health insurance marketplace regulated at the state level. Section 2706(a) of the Public Health Service Act preserves those protections by creating a federal provider non-discrimination provision that applies to all plans regulated by PPACA. Section 2706(a) prohibits insurance providers from discriminating, with respect to participation under the plan or coverage against health care providers acting within the scope of their state license of certification.

The above federal protection is needed because in today's delivery system, to reiterate, health plans often times discriminate against whole classes of providers based solely on their licensure or certification. Such discrimination is not only wrong in principle, but is anti-competitive in nature, limits or even denies patient choice and access to a range of beneficial providers, and, in general, results in a less than optimal delivery system. Additionally, ensuring that providers are not discriminated against in this fashion will encourage the placement and location of a wide range of skilled health care professionals in those areas of our nation currently without sufficient numbers of health care providers to adequately serve the public.

Section 2706 (a) and its Interpretation:

PPACA contains a non-discrimination provision, Section 2706 (a), which is part of the Public Health Service Act, entitled, "NONDISCRIMINATION IN HEALTH CARE." This provision states:

(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.¹ (Emphasis added)

ACA believes the underlined terms above are given broad application through their statutory definition² as follows:

(1) Group health plan: *The term “group health plan” means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002(1)]) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise. Relatedly, the term “medical care” means amounts paid for –*

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraph (A).

(2) Health insurance coverage: *The term “health insurance coverage” means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.*

(3) Participation: *The term “participation” means a payer cannot discriminate in the area of participation against a provider acting within their scope of practice. This does not mean the payer must allow every DC to participate, but plans are disallowed from excluding DCs as a provider group when determining who may be paid for providing a covered service.”*

(4) Health insurance issuer: *The term “health insurance issuer” means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1144(b)(2)]). Such term does not include a group health plan.*

It is also important to note that Section 2706(a) applies to all employee health benefit plans (insured and self-insured) and all health insurance policies (see below). By this definition, it does not include Medicare. It also does not apply to plans considered “grandfathered” as of January 1, 2014. (42 USC 300gg-91)

How Does Section 2706 (a) Apply?

Given the above, it is ACA’s view that Section 2706(a) applies in the following situations:

¹ <http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>

² <http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap6A-subchapXXV-partC-sec300gg-91.pdf>

- When there is evidence that DCs are being reimbursed at a different level than other providers for the same covered service and such discrimination is not based on quality or performance measures, but is based in whole or in part upon licensure and anticompetitive bias which perpetuates deleterious monopolistic practices;
- When there is evidence that an insurer or group health plan is, for example, applying caps on specific services provided by DCs, and such caps are not being applied to other providers based in whole or in part upon licensure;
- When there is evidence that the insurer or group health plan is denying specific forms of care otherwise covered under the plan on the basis that it is provided by a DC, and the covered service is within the scope of practice of a DC;
- When there is evidence that DCs are being excluded as a group from participation in a network's plan; and
- When services provided by chiropractic physicians are denied not based on training, competency and legal licensure to provide those services, but rather on type of provider.

Section 2706(a) applies to all group health plans, both insured and self insured, and it is not subject to any notion of ERISA preemption. The law provides that the state has the first responsibility to enforce Section 2706(a), and if the state does not enforce, then it falls to the HHS Secretary to do so.

The state of Connecticut is an example of a state which has adopted legislation to enforce Section 2706(a) and the other market reforms passed under PPACA. Chapter 700c, §38a-591(b) (2011), of the General Statutes of Connecticut, reads:

Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation and health care center licensed to do business in the state shall comply with sections 1251, 1252, and 1304 of the Affordable Care Act and the following Sections of the Public Health Service Act, as amended by the Affordable Care Act: (1) 2701 to 2709, inclusive, 42 USC 300gg et se; (2) 2711 to 2719A, inclusive, 42 USC 300gg-11 et seq.; and (3) 2794, 42USC 300gg-94.³

The Flawed Frequently Asked Questions (FAQ) Document:

On April 29, 2013, the Center for Consumer Information and Insurance Oversight (CCIIO) published Set 15 of its PPACA implementation FAQs⁴, which included a section on provider nondiscrimination and Section 2706(a). Unfortunately the FAQ includes information that is misleading and inaccurate and that we believe would change the meaning of the law. In the first paragraph of the provider nondiscrimination section CCIIO compares Section 2706(a) to nondiscrimination provisions in certain Medicare and Medicaid plans. This comparison could be misleading by implying that Section 2706(a) operates the same way as the Medicare and Medicaid nondiscrimination provisions. Although each of these provisions uses similar language, they apply to different payers under very different statutory and regulatory schemes. The Medicare and Medicaid provisions allow for certain types of discrimination that are not found in Section 2706(a), so this comparison should be removed.

CCIIO also incorrectly states: "This provision does not require plans or issuers to accept all types of providers into a network." This is inaccurate and misleading. While 2706(a) does not require insurers to contract with any willing provider, it also clarifies that insurers may not discriminate against a particular type of provider. An exclusion of all providers of a particular "type" would be discriminatory against that type of provider, not permissible under the law, and a blatant violation of the intent of the legislation.

³ http://www.cga.ct.gov/2013/pub/chap_700c.htm#sec_38a-591

⁴ http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html

The FAQ creates potential exceptions to Section 2706(a) where none exist. Section 2706(a) does not create any exceptions in coverage. In the answer to the FAQ, CCIIO says that coverage may be consistent with “reasonable medical management techniques.” This statement is misleading because discrimination based on licensure is a financial management technique, not a medical management technique. Furthermore, the statement is inaccurate because no language in Section 2706(a) exempts or protects medical management techniques. Just as PPACA prohibits medical management techniques that discriminate against enrollment of patients with preexisting conditions, the law disallows medical management techniques that discriminate in coverage against providers acting within the scope of their license. Therefore the reference to medical management techniques should be eliminated.

CCIIO creates another incorrect exemption by stating Section 2706(a) “does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards or considerations.” Section 2706(a) directly contradicts this because the language of the statute says that it does not prohibit insurers from “establishing varying reimbursement rates based on quality or performance measures.” CCIIO’s answer also implies that Section 2706(a) would allow insurers to discriminate based on “market standards and considerations,” where no exception exists. This exception would actually allow the type of discrimination that Section 2706(a) was designed to prohibit, because “market standards and considerations” could include paying health care providers different rates based on their license. Insurers should not be able to vary reimbursements on the basis of the factor of provider licensure when various qualified licensed provider types are delivering the same quality service. Due to the inaccuracy of this sentence, it should be removed.

This flawed FAQ has created confusion in many states, and those charged with implementing PPACA may indeed be drawing conflicting conclusions based upon the document’s ambiguity and false application. Congress enacted Section 2706(a) to protect patients and health care providers from discrimination, and improve access to care. It would be inappropriate to change the meaning of the law, particularly if the changes allow the type of discrimination the law meant to prohibit. We ask that you revise the FAQ to accurately conform to the language of Section 2706(a) by removing all misleading and inaccurate statements.

Congressional Intent Regarding Section 2706(a):

The Senate Appropriations Committee also found issue with the CCIIO FAQ and issued a rebuke of the verbiage found in the response. In specific response to the FAQ, the Senate Committee on Appropriations Report, dated July 11, 2013 (113-71, to accompany S. 1284), included the following language:

Section 2706 of the ACA prohibits certain types of health plans and issuers from discriminating against any healthcare provider who is acting within the scope of that provider’s license or certification under applicable State law, when determining networks of care eligible for reimbursement. The goal of this 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. The Committee is therefore concerned that the FAQ document issued by HHS, DOL, and the Department of Treasury on April 29, 2013, advises insurers that this nondiscrimination provision allows them to exclude from participation whole categories of providers operating under a State license or certification. In addition, the FAQ advises insurers that section 2706 allows discrimination in reimbursement rates based on broad “market considerations” rather than the more limited exception cited in the law for performance and quality measures. Section 2706 was

*intended to prohibit exactly these types of discrimination. The Committee believes that insurers should be made aware of their obligation under section 2706 before their health plans begin operating in 2014. The Committee directs HHS to work with DOL and the Department of Treasury to correct the FAQ to reflect the law and congressional intent within 30 days of enactment of this act.*⁵

ACA agrees with the Senate Appropriations Committee's assessment; however until such time as the problem is addressed, the FAQ and its misleading and mistaken information persist, threatening the very foundation of Section 2706(a) and undermining Congress' intent behind including the provision as one of the insurance reforms of PPACA.

Further Administration Inconsistencies:

Adding to the confusion already promulgated by the misleading CCIIO FAQ, Jonathan Blum, then-Principal Deputy Administrator at the Centers for Medicare and Medicaid Services, responded to a petition to the White House regarding the role of naturopaths in PPACA, stating:

*The law [Section 2706(a)] also provides that a health plan or insurance issuer 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 licensure or certification under applicable state law. The law does 'not require that a group health plan or health insurance issue contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer,' and does not prevent a 'group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.' We also note that this requirement address the type of providers included in a network, not which services are covered.*⁶

Here, we believe, Mr. Blum interpreted Section 2706(a) correctly. Mr. Blum's interpretation did not veer from the statute and did not add puzzling, superfluous and extraneous language found in the CCIIO FAQ. This official Administration response, however, only adds to the confusion being perpetrated from the White House on this issue, again leaving states and health plans issuers nothing but confused. This only further sustains media reports claiming the Administration is not talking clearly internally, resulting in a less than desirable implementation process.

Conclusion:

In closing, ACA believes that Section 2706(a) is a vital component of the Patient Protection and Affordable Care Act, embodying the president's goals of better access, increased cost efficiency, and enhanced quality. The ability for patients to actually take a role in choosing the provider of their choice is integral in the further implementation of PPACA. If cost, quality, and access are indeed the pillars of health reform, Section 2706(a) should be considered a linchpin to the Act's success.

With that, ACA finds the language found in 2706(a) to be self-executing and needs no further interpretation by the Administration or formal rulemaking. ACA believes the language found in Section 2706(a) is a clear, unambiguous mechanism aimed at eliminating the scourge of provider discrimination currently found in this nation's health care delivery system.

⁵ <http://www.gpo.gov/fdsys/pkg/CRPT-113srpt71/pdf/CRPT-113srpt71.pdf>

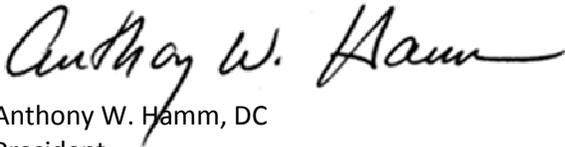
⁶ <https://petitions.whitehouse.gov/response/naturopathic-physicians-and-affordable-care-act>

That said, ACA believes the CCIIO FAQ needs to be repealed or amended immediately. As stated previously, this inconsistent message incorrectly interprets the 2706(a) statute and has led to nothing but confusion and chaos, especially at the state level. The congressional intent of Section 2706(a) is clear, as demonstrated by the Senate Appropriations Committee report language, referenced earlier. Again, Senate Report 113-71 clearly demonstrates that the FAQ is flawed and needs to be amended to better reflect the 2706(a) statute immediately.

Finally, as also contained in PPACA, states have the first opportunity to enforce many of the consumer protections found in the law, including Section 2706(a). Connecticut is just one state where Section 2706(a) enforcement is included in state law. However, in the majority of states, enforcement of Section 2706(a) and other consumer protection provisions found in PPACA will be the responsibility of HHS. Therefore, it is paramount that the federal government upholds, and enforces to the greatest extent possible, the language in Section 2706(a) as clearly demonstrated in the statute. Anything less than this, ACA believes, is in violation of the law, diminishes the concept of health reform, and seriously harms the patient.

If you have any questions about ACA's comments, please contact John Falardeau, Senior Vice President for Government Relations, at jfalardeau@acatoday.org. Thank you in advance for your attention in this regard.

Sincerely,

A handwritten signature in black ink that reads "Anthony W. Hamm". The signature is written in a cursive, flowing style.

Anthony W. Hamm, DC
President