March 6, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9929–P
P.O. Box 8016
Baltimore, MD 21244–8016

Submitted electronically to regulations.gov

Re: CMS–9929–P: Patient Protection and Affordable Care Act; Market Stabilization

Dear Sir/Madam:

On behalf of the American Nurses Association (ANA), we are pleased to comment on the proposed rule concerning the calendar year (CY) 2018 Patient Protection and Affordable Care Act; Market Stabilization—Proposed Rule.

The American Nurses Association (ANA) is the premier organization representing the interests of the nation's 3.6 million registered nurses (RNs), through its state and constituent member associations, organizational affiliates, and individual members. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions including essential self-care, and provide advice and emotional support to patients and their family members. ANA members also include the four advanced practice registered nurse roles (APRNs): nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs) and certified registered nurse anesthetists (CRNAs).[1] ANA is dedicated to partnering with health care consumers to improve practices, policies, delivery models, outcomes, and access across the health care continuum.

ANA's comments will focus on the issue of Network Adequacy. In the proposed rule CMS is announcing a retreat from an active federal role in assessing network adequacy.

[1]The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

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> "In recognition of the traditional role States have in developing and enforcing network adequacy standards, we propose to rely on State reviews for network adequacy in States in which an FFE is operating, provided the State has a sufficient network adequacy review process. . ."
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> "We [CMS] are also proposing a change to our approach to reviewing network adequacy in States that do not have the authority and means to conduct sufficient network adequacy reviews. In those States, we would, for the 2018 plan year, apply a standard similar to the one used in the 2014 plan year. As HHS did in 2014, in States without the authority or means to conduct sufficient network adequacy reviews, we would rely on an issuer's accreditation (commercial or Medicaid) from an HHS recognized accrediting entity. HHS has previously recognized 3 accrediting entities for the accreditation of QHPs: the National Committee for Quality Assurance, URAC, and Accreditation Association for Ambulatory Health Care. We would recognize these same three accrediting entities for network adequacy reviews for the 2018 plan year."

ANA has repeatedly recommended that CMS take a more active rather than a less active role in assuring QHP's network adequacy performance. While health insurance plans have recently been accused of ignoring consumer preferences through creation of narrow networks, there is a longer period of insurers' development of what may be called narrow-minded networks. In particular, there is the well documented insurer practice of excluding APRNs from participating in private health insurance networks.[2]

The American College of Nurse-Midwives (ACNM) recently completed a survey of federal marketplace insurers regarding coverage of midwifery services. Among their findings: 17% of plans do not cover primary care services offered by CNMs even though ACNM standards defining the scope of practice for these providers include primary care services, and 14% of plans indicated they impose restrictions on CNM practice that conflict with their scope of practice under state laws and regulations. Restrictions on APRN credentialing deprive ACA patients and families of access to services that by law are part of the Medicare benefit package. There is no legitimate business purpose in such restrictions. In fact, there is an additional concern that applies when the markets in question include the State-based Health Insurance Exchanges and the Federally-facilitated Marketplaces. In particular, the markets established under the authority of the Affordable Care Act are also required to abide by PPACA §1201 [now §2706(a) of the U.S. Public Health Service Act],

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[2] Institute of Medicine. The Future of Nursing: Leading Change, Advancing Health. Washington, DC: National Academies Press, 2010.
Hansen-Turton T, Ritter A, Begun H, Berkowitz SL, Rothman N, Valdez B. Insurers' contracting policies on nurse practitioners as primary care providers: The current landscape and what needs to change. Policy Polit Nurs Pract 2006;7:216–226.
Hansen-Turton T, Ritter A, Torgan R. Insurers' contracting policies on nurse practitioners as primary care providers: Two years later. Policy Polit Nurs Pract 2008;9:241–248.
Tine Hansen-Turton, JD, MGA, FCPP, FAAN, Jamie Ware, JD, MSW, Lisa Bond, PhD, Natalie Doria, BN, JD, RN, CHC, and Patrick Cunningham, "Are Managed Care Organizations in the United States Impeding the Delivery of Primary Care by Nurse Practitioners? A 2012 Update on Managed Care Organization Credentialing and Reimbursement Practices," Population Health Management, 2013 Oct;16(5):306-9. doi: 10.1089/pop.2012.0107. Epub 2013 Mar 29.

Non-Discrimination in Health Care: Providers. §2706(a) states that 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."

ANA's interest is not for preferred treatment but for a level playing field. In particular, with respect to any qualified private health plan that applies to participate in a State Health Insurance Exchange, the following rule should apply. If a State's essential health benefits choices are implemented in specific covered health care services, then the network candidacy of any licensed clinician within that State who can provide those services within the State's approved scope of practice should undergo the same vetting. If successfully vetted, the candidate's subsequent approval should proceed, becoming credentialed for that Plan's network of approved providers. Plans with blanket exclusion rules with respect to categories of clinicians should not be allowed to participate in the Exchanges. CMS should not and cannot walk away from its obligation to enforce the requirements under §2706(a).

ANA welcomes an opportunity to further discuss network adequacy and other issues related to recognizing the contributions of APRNs. If you have questions, please contact Mary Beth Bresch White, Director, Health Policy (marybreschwhite@ana.org).

Sincerely,

Debbie Hatmaker

Debbie D. Hatmaker, PhD, RN, FAAN
Executive Director / Executive Vice President

cc: Pamela Cipriano, PhD, RN, NEA-BC, FAAN, ANA President
Marla Weston, PhD, RN, FAAN, ANA Chief Executive Officer