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Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, D.C. 20201

Re: CMS–9942–NC

Dear Ms. Tavenner:

The American Society of Anesthesiologists ("ASA"), the American Academy of Ophthalmology ("AAO"), the American Association of Orthopaedic Surgeons ("AAOS"), and the American Academy of Otolaryngology-Head and Neck Surgery ("AAO-HNS") appreciate the opportunity to respond to the March 12, 2014 Request for Information ("RFI") issued by the Departments of Health and Human Services, Treasury, and Labor (collectively, "the Departments"). The RFI seeks comments on the Departments' interpretation of § 2706(a) of the Public Health Services Act, which includes the provider non-discrimination provisions added by the Affordable Care Act. The Departments' interpretation was issued through an FAQ document they jointly published on April 29, 2013. The Senate Appropriations Committee has questioned the Departments' interpretation as being inconsistent with the non-discrimination language of § 2706(a).

We support the Departments' efforts to meet the non-discrimination purposes of § 2706(a) while also seeking to give health plans and insurance issuers sufficient flexibility in selecting their provider panels to ensure their beneficiaries receive high quality care. Our support for the Departments' position is based on the plain language of § 2706(a) and the need to ensure health plans and insurance issuers offer the most qualified providers to their participants. Additionally,

we support the Departments' position, based on consistency with previous CMS interpretations of provider non-discrimination laws and practical need, to allow insurers to consider market factors to attract and retain a range of providers.

BACKGROUND

Section 2706(a) states:

> 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]

Based on this language, the Departments issued the following FAQ:

> **Provider Non-Discrimination**
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> PHS Act section 2706(a), as added by the Affordable Care Act, 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." PHS Act section 2706(a) does 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," and nothing in PHS Act section 2706(a) prevents "a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures." Similar language is included in section 1852(b)(2) of the Social Security Act and implementing HHS regulations.[2]

In response to a separate FAQ on whether the Departments would be issuing implementing regulations, the Departments added:

> Until any further guidance is issued, group health plans and health insurance issuers offering group or individual coverage are expected to implement the requirements of PHS Act section 2706(a) using a good faith, reasonable interpretation of the law. For this purpose, to the extent an item or service is a covered benefit under the plan or coverage, and consistent with reasonable medical management techniques specified under the plan with respect to the frequency, method, treatment or setting for an item or service, a plan or issuer shall not discriminate based on a provider's license or certification, to the extent the provider is acting

[1] The Protection and Affordable Patient Care Act, H.R. 3590, § 1201 amending the Public Health Services Act, §2706 (codified at 42 USC § 300gg).
[2] Health and Human Serv., Dept. of Labor, and Dept. of Treasury, FAQs About Affordable Care Act Implementation (Part XV), http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html (last accessed June 5, 2014) (citations omitted).

> within the scope of the provider's license or certification under applicable state law. This provision does not require plans or issuers to accept all types of providers into a network. This provision also does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.

The Senate Appropriations Committee issued a report (to accompany S. 1284) on July 11, 2013, expressing concern that the Department's interpretation would allow health plans and insurance issuers to exclude from participation whole categories of providers operating under a State license or certification. The Committee report also stated that § 2706(a) was intended to preclude discrimination in reimbursement rates based on broad market considerations rather than performance and quality measures.[3]

DISCUSSION

We support the Departments' interpretation of § 2706(a) for the following reasons:

1. The plain language of § 2706(a) supports the Departments' interpretation.

The plain language of § 2706(a) requires a construction of the statute that allows insurers to distinguish between provider types to ensure patient safety and quality of care. The first sentence of § 2706(a) prohibits provider discrimination, but it also clearly contemplates that health insurers may make distinctions among providers who are acting within the scope of their license/certification status and those who are not.

The second sentence of § 2706(a) indicates that plans and other insurers are not required to have contracts with any willing provider. This clearly means that health plans and insurers can make distinctions among providers acting within the scope of their licensure or certification. Canons of statutory construction require that statutory interpretations that would render any provision of a statute superfluous or meaningless should be avoided.[4] For the second sentence of § 2706(a) to have separate meaning from the first sentence of the statute, it must be interpreted to allow insurers to make additional distinctions within and between provider types where necessary, as long as they are not solely based on a provider's licensure or certification status. Such distinctions can be based on limitations in the size of provider networks; qualifications, experience, and past performance of providers; or any other legitimate factor that is not tied solely to a provider's license or certification status.

In addition, the second sentence of the statute applies to *any* health care provider. This indicates that plans and insurance issuers are to be given broad latitude when making decisions about the providers with which they choose to contract. The FAQ's statement that "[t]his provision does not require plans or issuers to accept all types of providers into a network" is therefore plainly consistent with the statute.

The third sentence of the statute clearly allows health plans and insurance issuers, and the Secretary, to vary reimbursement rates based on quality or performance measures. Contrary to the concerns expressed by the Senate Appropriations Committee, this language is not limited to specific types of quality and performance measures. Rather, it gives plans, issuers, and the

[3] S. Rep. No. 113–71, at 126 (2013).

[4] *See e.g.*, *Astoria Federal Savings & Loan Ass'n v. Solimino*, 501 U.S. 104, 112 (1991) (citing *United States v. Menasche*, 348 U.S. 528, 538–39 (1955).

Secretary broad discretion to take into account a wide range of performance and quality-related factors in setting payment levels for all types of providers, including market considerations. The obvious purpose of this broad language is for plans, insurance issuers, and the Secretary to be able to pay providers rates that are commensurate with their skill and expertise and to pay sufficient amounts to attract and retain high quality providers.

2. ***Plans and issuers must be able to make distinctions between provider types to ensure patient safety and quality of care.***

Allowing health plans and insurance issuers to make distinctions between providers based on qualifications, both in terms of selection criteria and payment rates, is critical to ensuring patients receive safe, high quality care. These distinctions can be among providers of different types—*e.g.*, physicians and non-physicians—or of the same type—*e.g.*, physicians versus physicians. However, distinctions between physicians and non-physicians have particularly important consequences for patient outcomes.

Diagnoses, treatments, and procedures to address medical conditions are often complex and must be performed by appropriately-trained physicians. For example, neurodestruction (the injection of drugs directly into the nerve to destroy it) is used by physician anesthesiologists to treat pain. If not performed correctly by a highly-trained physician anesthesiologist (as opposed to a nurse anesthetist or a physician who lacks training in this procedure), it can result in reduced blood flow leading to paraplegia, stroke or death. Invasive cancers sometimes begin on the eyelid, requiring that large portions of the eyelid be removed to prevent the cancer from spreading. Such procedures must be performed by qualified ophthalmologists. Optometrists do not have the training to address these cancers, even if they might otherwise be permitted under state scope of practice laws to perform some eyelid surgeries. Successful diagnosis in these cases depends on the involvement of a physician pathologist to examine the cancer before it spreads.

Physicians have more education and training than nurse practitioners, physician assistants, and other non-physician provider types, which enables them to provide more accurate diagnosis and effective treatment and to better address complications that can arise.

Physicians must complete four years of post-graduate education and between three and eight years of residency and fellowship, for a total of seven to twelve years of post-graduate training. This includes a total of 12,000 to 16,000 patient care hours.[5] Most physician specialists are required to take additional certification examinations from an American Board of Medical Specialties certification board, such as the American Board of Orthopaedic Surgeons, the American Board of Ophthalmology, the American Board of Otolaryngology, and the American Board of Anesthesiology.

Non-physician practitioners, on the other hand, have significantly less training. For example:

- Audiologists complete four years in graduate-level education, a one-year residency or fellowship and 1,820 patient care hours.[6]

[5] Am. Med. Ass'n, *Know Your Doctor*, (2013).
[6] *Id.*

- Optometrists complete four years of graduate level education, are not required to complete a residency or fellowship and *may* complete a one-year, optional clinical rotation or "residency."[7]
- Nurse anesthetists complete two to three years of graduate-level education and are not required to complete a residency or fellowship;[8] rather, they complete 1,650 patient care hours.[9]
- Podiatrists may be certified by one of several boards offering podiatry certification but there are no standardized requirements for podiatrists as to years of education and training or hours of patient care. During their training, podiatrists typically complete four years of education and provide patient care for a period of 80 weeks. [10]
- The majority of physical therapists do not have a graduate degree in physical therapy.
- Chiropractors receive four years of post-graduate education, and see approximately 320 patients during training.[11]

The distinctions between physicians and other provider types are not just based on differences in education and training. Numerous studies demonstrate that patients have better outcomes if their care is provided or supervised by appropriately-trained physicians. For example, the likelihood of an "unexpected disposition," *i.e.*, an outcome following low-risk surgery other than sending the patient home the same day, is 80 percent higher when anesthesiology care is provided by a nurse anesthetist without physician involvement.[12] Another study found that there are 2.5 excess deaths within 30 days of a patient's admission per 1000 cases when anesthesiology care is provided exclusively by a nurse anesthetist as opposed to a physician anesthesiologist.[13]

Non-physician providers are key contributors to the physician-led patient care team. But for such teams to be effective, physicians need to be intimately involved in the treatment of patients. Health plans and insurance issuers therefore need to have the flexibility to develop physician-led patient care teams with the right mix of physicians and non-physician providers.

Thus, within the boundaries of state licensure and scope of practice laws, there are important policy reasons why Congress and the Departments have allowed for some additional distinctions between physicians and other provider types that are merited by differences in education and training that directly affect the quality and safety of patient care. The statute, of course, also allows for health insurers to distinguish between physicians of different specialties or within the same specialty based on training and other qualifications.

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[7] *Id.*
[8] *Id.*
[9] Am. Ass'n of Nurse Anesthetists, *Qualifications and Capabilities of the Certified Registered Nurse Anesthetist*, https://www.aana.com/ceandeducation/becomeacrna/Pages/Qualifications-and-Capabilities-of-the-Certified-Registered-Nurse-Anesthetist-.aspx (last accessed June 4, 2014).
[10] *See* Am. Med. Ass'n, *supra* note 5.
[11] *Id.*
[12] Stavros G. Memtsoudis et al., *Factors Influencing Unexpected Disposition After Orthopedic Ambulatory Surgery*, 24 J. CLIN. ANESTHESIOLOGY 89 (2012).
[13] Jeffrey H. Silber, et. al., *Anesthesiologist Direction and Patient Outcomes*, 93 ANESTHESIOLOGY 153 (2003).

3. ***Health plans and insurance issuers must be able to set reimbursement rates based on a wide range of performance and quality-based factors, including market considerations.***

As noted above, the Departments' interpretation of § 2706(a), states that "[t]his provision . . . does not govern provider reimbursement rates, which may be subject to quality, performance, *or market standards and considerations.*"[14] Although market measures may not be explicitly mentioned in the statute, they are a principle proxy for quality and performance. Health plans and insurers clearly need to pay market rates to attract high quality providers, whether physicians or non-physicians.

As the mandatory insurance requirement of the Affordable Care Act inevitably expands the number of insured individuals and increases the demand for health practitioner services, it should become increasingly important to make sure that health plans and insurers can meet patient needs. Research currently projects a shortage of physicians, nurses, and physician assistants in the near future, in part because the number of new practitioners each year is not currently keeping pace with increased demand. [15] These shortages are likely to be particularly acute in rural and medically underserved areas.[16] This research also suggests, however, that a shortage in physicians cannot be addressed by increasing the number of other provider types.[17]

Expanding the number of nurses and physician assistants will not address a physician shortage in part because there are services that can only be provided by a physician or a physician-led patient care team. While shortages across all provider types will need to be addressed, to continue to encourage people to seek the education and training necessary to become a physician, insurers will need to set payment rates in part based on market conditions. The Affordable Care Act was not designed to expand demand without also providing the means to address supply side issues.

Finally, even when physicians are paid at higher rates than non-physician provider types, physician-led patient care can still reduce overall costs. For example, in one *New England Journal of Medicine* study, the involvement of a physician anesthesiologist in the provision of anesthesiology services compared to care provided by nurse anesthetists alone was found to decrease medical consultation requests by 75 percent, the costs of laboratory tests by 59 percent, and the cancellation of operations, also a driver of costs, by 88 percent.[18] As stated previously, physician involvement in patient care also led to fewer "unexpected dispositions" and better patient outcomes.[19] This same study concluded that these unexpected dispositions increased health costs overall because of the additional services necessary to address poorer patient outcomes.[20] Likewise, CMS has concluded that requiring physician referrals for audiology tests conducted by audiologists (rather than direct access) is necessary to ensure that beneficiaries

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[14] *See* Health and Human Serv., Dept. of Labor, and Dept. of Treasury, FAQs, *supra* note 2 (emphasis added).
[15] Michael Sargen et. al., *Gaps in the Supply of Physicians, Advance Practice Nurses, and Physician Assistants*, __ J. AME. COLLEGE OF SURGEONS 1 (2011).
[16] *See cf.* Ass'n of Ame. Med. Colleges, *Recent Studies and Reports on Physician Shortages in the U.S.*, (2012), *available at* https://www.aamc.org/download/100598/data/ (discussing recent research on physician shortages in the 50 states, which tend to be particularly acute in rural areas).
[17] *See* Sargen, *supra* note 15.
[18] Richard A. Wiklund and Stanley H. Rosenbaum, *Anesthesiology*, 337 NEW ENGLAND J. MED. 1132 (1997).
[19] *See* Memtsoudis, *supra* note 12.
[20] *Id.*

receive and Medicare pays for only medically necessary services and not asymptomatic screenings.[21] Thus, reference to market conditions is a critical factor in setting different payment rates for different providers and to ensure quality care while limiting overall healthcare costs.

4. ***Allowing health plans to distinguish among provider types is consistent with previous CMS interpretations of provider non-discrimination laws.***

The Centers for Medicare and Medicaid Services ("CMS") has previously interpreted provider non-discrimination provisions in the Social Security Act ("SSA") with respect to Medicare Advantage and the Medicaid Managed Care program, passing regulations implementing these provisions in 2000 and 2002 respectively. In each of these cases, CMS' interpretation of the relevant provider non-discrimination provision was consistent with the Departments' interpretation of § 2706(a).

SSA § 1852(b)(2),[22] the provider non-discrimination provision that applies to Medicare Advantage, states that:

> A Medicare+Choice organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.[23]

CMS implemented this statute in 42 C.F.R. § 422.205. This regulation is substantially similar to the statutory language in SSA § 1852(b)(2). In the 2000 final rule that was codified at 42 CFR § 422.205, CMS clarified that "[i]f an M+C organization can provide all physicians' services through a doctor of medicine, it may not "need" to contract with another practitioner who can provide only a discrete subset of physicians' services (such as a podiatrist or a chiropractor . . .)."[24] CMS also stated that "[a]s long as all Medicare-covered services are available in the plan, there may be no 'need' to assume the additional administrative costs of contracting with another practitioner when an existing contractor is able to perform the services the additional practitioner would be providing."[25]

SSA § 1932(b)(7),[26] the provider non-discrimination provision that applies to Medicaid managed care, uses the same language as SSA § 1852(b)(2), and CMS promulgated substantially similar regulations implementing this statutory provision for Medicaid, *see* 42 CFR § 438.12, as it had for Medicare Advantage. CMS also stated that it did not believe that the statute or the regulations would "handicap" managed care organizations in selecting their networks "on the basis of quality and market need" because the provisions of the statute and regulations do "not

[21] *See, e.g.*, Ctrs for Medicare & Medicaid Servs., *Report to Congress: Direct Access to Licensed Audiologist Under the Fee for Service Medicare Program Medicare Funding of Second Year* (2007).
[22] Social Security Act § 1852(b)(2) (codified at 42 USC § 1396w-22).
[23] *Id.*
[24] 65 Fed. Reg. 40,170 , 40,237 (June 29, 2000).
[25] *Id.*
[26] Social Security Act § 1932(b)(7) (codified at 42 USC § 1395u-2)

require entities to contract with any willing provider."[27] Similarly, § 2706(a) does not require health plans and insurers to contract with any willing provider.

While SSA § 1932 and § 1852 both focus on managed care plans, much of the same analysis can be applied to insurers developing networks as part of group health plans under the Affordable Care Act. It is at least clear from these past regulations that CMS has historically interpreted provider non-discrimination provisions that do not require "any willing provider" contracting as permitting insurers to distinguish between provider types in forming their provider networks. Congress clearly was aware of these interpretations in crafting § 2706(a) of the ACA and knew or should have known that CMS would interpret § 2706(a) in a similar manner. Had it intended to direct CMS to take a different approach, it could have said so explicitly.

Interpreting quality and performance measures to include market conditions is also consistent with past CMS interpretations of provider non-discrimination statutes applied to Medicaid Managed Care and Medicare Advantage. SSA § 1932(b)(7) and § 1852(b)(2) contain no statutory provision explicitly allowing health insurers to "establish varying reimbursement rates based on quality or performance measures." Yet, CMS regulations implementing SSA § 1932(b)(7) state that "this section may not be construed to— . . . (2) Preclude [managed care organizations] from using different reimbursement amounts for different specialties or for different practitioners in the same specialty . . ." 42 CFR § 438.12(b). Likewise, 42 CFR § 422.205(b), implementing SSA § 1852(b)(2), provides that Medicare Advantage organizations are not precluded from the "(2) Use of different reimbursement amounts for different specialties or for different practitioners in the same specialty."

Both of these regulations also go on to clarify that insurers may establish "measures designed to maintain quality and control costs." When Congress added language to § 2706(a) similar to these regulations, it did so with full awareness of CMS' previous interpretation of provider non-discrimination provisions allowing distinctions among providers as to payment and with reference to market conditions or cost control measures.

5. ***Allowing health plans and insurance issuers to make distinctions among providers does not interfere with state licensure or scope of practice laws or regulations, but does recognize that certain providers are more qualified than others to perform certain health care services.***

The Departments' interpretation of § 2706(a) does not allow health plans and insurance issuers to discriminate against providers based on the type of license or certification they possess and therefore does not interfere with state licensure or scope of practice laws or regulations. To the contrary, the FAQ follows the terms of the statute when it states:

> For this purpose, to the extent an item or service is a covered benefit under the plan or coverage, and consistent with reasonable medical management techniques specified under the plan with respect to the frequency, method, treatment or setting for an item or service, a plan or issuer shall not discriminate based on a provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under applicable state law.

[27] 67 Fed. Reg., 40,989, 41,019 (June 14, 2002).

Thus, distinctions that plans and issuers make among providers must be based on factors other than the type of license or certification that a provider possesses. In setting these boundaries, Congress was deferring to state authority and expertise in licensing the health professions and defining their scope of practice, an area of the states' inherent police powers that courts have recognized for over a century.[28]

But, as previously noted, the statute also states that health plans and insurance issuers are not required to contract with any willing provider, which implies that they may distinguish within and between provider types in establishing their provider networks. Indeed, state scope of practice determinations are often so broad, that health plans have no choice but to make distinctions among a wide array of providers who are permitted by state scope of practice laws or regulations to perform the same procedure.

For example, Louisiana recently passed the Optometric Scope Expansion Act, H.B. 1065, which defines the practice of optometry to include the ability to perform ophthalmic surgery, including, but not limited to, scalpel eyelid surgeries on lesions, cysts and chalazia, glaucoma laser surgery and YAG laser capsulotomy. [29] Complications of scalpel and laser eye surgeries include eye damage, visual loss, and blindness. The statute also provides that the Louisiana State Board of Optometry Examiners "shall be responsible for the control and regulation of the practice of optometry" and may regulate the educational and licensing requirements of optometrists who may perform the additional procedures outlined in the statute.[30] Supporters of the bill have indicated that an optometrist would be required to complete a 32-hour training course before becoming licensed to perform scalpel eyelid and laser surgeries.[31] But a health plan or insurance issuer could reasonably determine that 32 hours of surgical training hardly makes up the gap between an ophthalmic surgeon and optometrist and contract primarily with the former to perform these eye surgeries.

Similarly, a Kentucky statute recently allowed optometrists to perform laser procedures, including laser trabeculoplasty, peripheral iridotomy, iridoplasty and capsulotomy; some incisional or scalpel based surgeries; pharmaceutical agent administration, including via injection; and local and regional anesthesia. [32] Misapplied injections around the eye can result in blocked arteries or eye perforation, and misapplied anesthesia injections can cause the patient to stop breathing, requiring emergency cardiopulmonary resuscitation. This statute also gave the state Board of Optometry "sole authority" to define the scope of practice of optometry, effectively removing that authority from the state Board of Medicine.[33] This provision effectively empowers the Board of Optometry to determine which procedures an optometrist

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[28] *See, e.g., Semler v. Oregon State Board of Dental Examiners*, 294 U.S. 608 (1935); *Hawker v. People of New York*, 170 U.S. 189 (1898); *Dent v. State of West Virginia*, 129 U.S. 114 (1889).
[29] H.B. 1065 (La. 2014) (codified at LA. REV. STAT. 37:1041, 1048(15), 1049(8)), *available at* http://www.legis.la.gov/legis/ViewDocument.aspx?d=898396
[30] *Id.*
[31] Emily Lane, *Bill Approved By Louisiana Legislature Lets Optometrists Perform Some Eye Surgeries*, THE TIMES-PICAYUNE, May 22, 2014 (discussing how supporters of H.B. 1065 had indicated that the training for optometrists to perform eye surgery would likely consist of a 32 hour course).
[32] Better Access to Quality Eye Care Act, S.B. 110, 11th Gen. Assemb., Reg. Sess. (Ky. 2014) (codified at KY. REV. STAT. §§ 320.210, 320.240), *available at* http://www.lrc.ky.gov/record/11rs/sb110.htm
[33] Better Access to Quality Eye Care Act, S.B. 110, 11th Gen. Assemb., Reg. Sess. (Ky. 2014) (codified at KY. REV. STAT. §§ 320.210, 320.240), *available at* http://www.lrc.ky.gov/record/11rs/sb110.htm

may safely perform without reference to the state Board of Medicine. Thus, while health plans doing business in Kentucky cannot exclude optometrists from performing laser procedures for scope of practice reasons, they may choose to contract with ophthalmologists to perform these procedures if they reasonably determine that ophthalmologists are more qualified and more likely to achieve better outcomes for plan beneficiaries.

As yet another example, state scope of practice and licensure laws in many states do not prevent chiropractors from using chiropractic manipulation to treat ear infections. As a result, the American Chiropractic Association and many individual chiropractors have begun to promote and advertise the use of chiropractic medicine to address ear infections, even among young children.[34] The Mayo Clinic, and likely other major health care systems as well, warn against the use of chiropractic treatment for ear infections, particularly for children, both because these treatments have not yet been examined in long-term studies and because children are more likely to suffer injury from some types of chiropractic manipulation.[35] Because of these risks, it would be appropriate for an insurer to choose to contract with otolaryngologists, pediatricians, or other appropriately-trained physicians to treat ear infections, and not chiropractors.

Podiatrists are also subject to widely varying state scope of practice laws ranging from allowing podiatrists to perform foot-only procedures to ankle procedures to procedures that may cover the entire leg. In some cases, podiatrists are allowed to perform toe, partial foot or whole foot amputations. They may even be allowed to perform general anesthesia. While the AAOS has worked with state Podiatric Associations to create guidelines for hospitals regarding the necessary training before podiatrists may receive privileges to perform these surgeries, this does not mean that all hospitals may follow them.[36] Section 2706(a) surely does not require insurers to allow podiatrists to perform surgical or other procedures for which orthopaedic surgeons have superior training or where the insurer has concerns about the training and privileges of podiatrists.

Finally, physical therapists are increasingly advocating for an expanded scope of practice that would allow them to treat patients without a physician referral or consultation. They are also advocating in some states for the ability to diagnose musculoskeletal disorders without physician supervision. Physical therapists do not receive any training as to the diagnosis of these ailments nor are they trained to identify and address the wide range of illnesses that could be the root cause of a patient's ailment. For example, shoulder pain, while it might appear to be a strained muscle, could actually be a form of shoulder cancer, which physical therapists are not trained to identify. If physical therapists are legally able to diagnose musculoskeletal disorders without physician supervision, this could delay treatment of an undiagnosed cancer with life threatening consequences. Insurers may need to be able to make distinctions between physical therapists and physicians where necessary to ensure high quality care and patient safety, and, in some cases, to prevent life-threatening illnesses from going undiagnosed.

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[34] Ame. Chiropractic Ass'n, *Chiropractic Approach to Ear Infections*, http://www.acatoday.org/content_css.cfm?CID=69 (last visited June 4, 2014).
[35] Mayo Clinic, *Ear Infection Treatment: Do Alternative Therapies Work*, http://www.mayoclinic.org/diseases-conditions/ear-infections/in-depth/ear-infection-treatment/art-20047613 (last accessed June 4, 2014).
[36] *See, e.g.*, California Orthopaedic Ass'n, *Information on Podiatric Hospital Privileging*, (undated).

CONCLUSION

The Departments' interpretation of § 2706(a) is consistent with the plain language of the statute and supported by strong policy concerns related to patient safety and quality of care. Health plans and insurance issuers must be able to make distinctions among provider types within the boundaries of state scope of practice laws. In addition, insurers must be able to rely on market standards and considerations as a proxy for quality and performance in setting payment rates to maintain an adequate supply of highly-qualified providers, whether physicians or non-physicians. The Departments' interpretation of § 2706(a) is consistent with CMS's longstanding interpretations of other similar provider non-discrimination provisions—interpretations that Congress knew existed when § 2706(a) was enacted.

On behalf of ASA, AAO, AAOS, and AAO-HNS, we strongly support the Departments' interpretation of § 2706(a) and believe it is the most appropriate approach for ensuring that health plans and insurance issuers have the flexibility and discretion to develop provider networks that will protect patients and maintain quality of care within the boundaries of state scope of practice laws.

If you have any questions about these comments, the contacts for ASA, AAO, AAOS, and AAO-HNS are as follows:

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Respectfully submitted,

American Society of Anesthesiologists

American Academy of Ophthalmology

American Association of Orthopaedic Surgeons

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