



American Society of Transplant Surgeons

December 20, 2015

**Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017; Federal Register / Vol. 80, No. 231 / Wednesday, December 2, 2015 / Proposed Rules**

Dear Secretary Burwell:

On behalf of the American Society of Transplant Surgeons (ASTS), I am pleased to have this opportunity to comment on the network adequacy provisions of the *HHS Notice of Benefit and Payment Parameters for 2017* (the "Proposed Rule"). ASTS is a medical specialty society representing approximately 1,800 professionals dedicated to excellence in transplantation surgery. Our mission is to advance the art and science of transplant surgery through leadership, advocacy, education, and training.

The Proposed Rule would establish new requirements for Qualified Health Plans (QHPs) participating in Federally-Facilitated Exchanges (FFE). Our comments focus on those provisions of the Proposed Rule that address the network adequacy of Qualified Health Plans (QHPs) listed on FFEs and provider transition requirements for transplant centers and transplant teams.

**Provider Network Adequacy**

The Proposed Rule would rely primarily on state reviews to determine the adequacy of provider networks offered by QHPs; however, the states would be required to use an acceptable quantifiable network adequacy metric approved by HHS, which may include, among others, time and distance requirements. In those states that fail to propose an acceptable metric or choose not to conduct network adequacy reviews, such reviews would be conducted by FFEs, again using, among other standards, time and distance requirements.

*Comments: We believe that it is critical that the number and type of transplant centers made available by QHPs to their insureds be adequate. The types of "time and distance" access requirements that might be suitable for many types of services (e.g., primary care, general acute care hospital care, etc.), may not be appropriate to determine the adequacy of payer networks for transplantation. Moreover, we understand that there are health plans that have indicated that they are considering policies that would relocate enrollees to regional providers for transplantation rather than allowing them to stay local, for cost savings.<sup>1</sup> We urge HHS to establish special standards for specialized services, such as organ*

<sup>1</sup> Of the more than 5000 hospitals in the US, only about 250 offer solid organ transplant services, suggesting that in many cases there is already geographic regionalization.

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*transplantation, that are essential health benefits, since more general time and distance standards for primary care or for the more commonly performed physician specialty services and for general inpatient hospital services may not be sufficient to ensure access.*

## **Provider Transitions**

Under the Proposed Rule, issuers in FFEs must make a good faith effort to give written notice of a discontinued provider 30 days before the effective date of change or as soon as practicable to enrollees seen on a regular basis, or who receive primary care from the provider whose contract is being discontinued. CMS seeks comment on this proposed provision, including the timeframe for notification.

- *Comments: ASTS does not believe that 30 days constitutes sufficient notice when an offeror of a QHP terminates a transplant center or transplant team from its network. In this event, all of the QHP's insureds may be required to become listed on the wait list of another transplant center, which may considerably delay access to potentially life-saving procedures. Enrollees that have spent years on the wait list of a network transplant center may be required to essentially start all over again at a new center. Transplant Centers have heterogeneous selection criteria based on expertise, risk tolerance, and organ availability. Hence a patient who has been accepted as a candidate at one center is not guaranteed to be accepted as a candidate at another center. Moreover, although patients' waiting time can be transferred from one transplant center to another (either individually or en mass), most transplant centers will require that the patient undergo evaluation at their center before being considered active. This usually involves the patient being seen by multiple providers and then being presented at a CMS-mandated selection conference. The logistics of this reevaluation can be problematic, particularly in light of the proposed 30 day transition period.*

*In addition, not all transplant centers have comprehensive services or can accommodate patients with difficult clinical problems. For example, live donor liver transplantation is only performed at a handful of liver transplant programs and desensitization for live donor transplantation or ABO-incompatible transplantation is only performed at a minority of centers. Likewise, a study conducted by the ASTS Scientific Studies Committee demonstrated that only 44% of the estimated 240 kidney transplant programs in the U.S. participated in Kidney Paired Donation. Therefore, potential recipients de-listed from one Transplant Center may not be able to be listed at the Transplant Center chosen by the QHP to participate in its network.*

*Finally, there is empirical evidence that rapid transfer of multiple patients from one center to another for insurance coverage purposes does not work. For example, when Kaiser opened its own kidney transplant program in California, necessitating de-listing of approximately 1500 patients from UCSF and UC Davis, the Kaiser program did not have the infrastructure to accommodate this influx of patients, resulting in many patients missing opportunities for transplantation.*

*In light of these considerations, the de-listing of a Transplant Center has the potential to significantly impact transplant recipients—with repercussions that can be critical. For these reasons, we strongly urge HHS to require QHPs to continue to include transplant centers whose network participation is terminated or is not renewed (for reasons that do not pose a danger to health or safety) to continue to be treated as in-network providers for those QHP enrollees*

*included on the terminated center's wait list, unless it can be shown that re-listing will not adversely impact the enrollee's wait list status.*

Along related lines, under the Proposed Rule, when a provider is terminated without cause, QHPs must allow an enrollee "in active treatment" to continue treatment until the treatment is complete, or for 90 days, whichever is shorter, at in-network cost-sharing rates. "Active treatment" is defined to include ongoing treatment for a serious acute condition as well as "an ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes."

- *Comments: In response to increasing cost pressures, insurers are increasingly narrowing their provider networks and excluding providers. As discussed above, we believe that any enrollee who is listed on a transplant center's wait list be considered "in active treatment" for the purposes of this provision. Transplant care does not terminate upon transplantation, but rather usually requires long-term follow-up at the transplant center for management of immunosuppressive therapy. In addition, in light of the possibility of organ rejection and opportunistic infection, it is critical that transplant recipients continue to be considered in "active treatment" with the original transplant team for at least a year post-transplant.*

*We believe that this requirement would pose minimal burden on issuers of QHPs in light of the relatively limited number of insureds who likely would be impacted.*

ASTS very much appreciates the opportunity to comment on the Proposed Rule, and we hope that these comments are helpful.

Sincerely yours,

A handwritten signature in black ink, appearing to read 'Charles Miller', with a long horizontal flourish extending to the right.

Charles Miller, MD  
President  
American Society of Transplant Surgeons