

include a reference to the personnel qualifications at § 484.4.

- To meet the requirements at § 484.38, the Joint Commission revised its standards to address the additional health and safety requirements set forth in § 485.711, § 485.713, § 485.715, § 485.719, § 485.723, and § 485.727 of the Code of Federal Regulations (CFR) to implement section 1861(p) of the Act.

- To meet the requirements at § 484.48(b), the Joint Commission revised its standards to ensure clinical record information is “safeguarded against loss.”

- To meet the requirements at § 484.52, the Joint Commission revised its standards to ensure the HHA’s required annual self-evaluation assess the extent to which the agency’s program is appropriate, adequate, effective and efficient.

- To meet the requirements at § 484.52(b), the Joint Commission revised its standards to ensure the HHA include appropriate health professionals that represent “the scope of the program” in the required quarterly internal HHA review of a sample of clinical records.

- To meet the requirements at § 488.4(b)(3)(iii) and § 488.8(d)(1), the Joint Commission revised its policies to ensure that CMS is notified in advance of any proposed changes in its approved Medicare HHA accreditation program.

- To meet the requirements of the Joint Commission’s Appendix L “Addendum for Home Health Deemed Status Surveys”, the Joint Commission modified its policy to ensure surveyors conduct the required number of case reviews that include observing home visits.

- The Joint Commission amended its policy to clearly state that follow-up surveys following identification of condition-level non-compliance are conducted within 45 “calendar” days of the survey end date.

- During the review of the Joint Commission’s application, CMS issued notice to the Joint Commission with respect to all of its CMS-approved Medicare accreditation programs, in connection with its citation practices and its use of standards that are frequency-based and require a minimum frequency of observations of deficient practices before a citation will be made, so-called “C- weighted” standards. Due to the fact that this letter was released late in the review of the Joint Commission’s current HHA application, there was not sufficient time for the Joint Commission to fully implement and provide evidence of sustained compliance with the provisions of this notice. To verify compliance in this

area, CMS will conduct a follow-up survey observation and corporate onsite within one year of the date of publication of this notice.

B. Term of Approval

Based on the review and observations described in section III. of this final notice, we have determined that the Joint Commission’s requirements for HHAs meet or exceed our requirements. Therefore, we approve the Joint Commission as a national accreditation organization for HHAs that request participation in the Medicare program, effective March 31, 2014 through March 31, 2020.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

Dated: March 6, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

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DEPARTMENT OF THE TREASURY

Internal Revenue Service

DEPARTMENT OF LABOR

Employee Benefits Security Administration

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–9942–NC]

Request for Information Regarding Provider Non-Discrimination

AGENCY: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Request for information.

SUMMARY: This document is a request for information regarding provider non-discrimination. The Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively,

the Departments) invite public comments via this request for information.

DATES: Comments must be submitted on or before June 10, 2014.

ADDRESSES: Written comments may be submitted to HHS. Any comment that is submitted will be shared with the other Departments. Please do not submit duplicates. All comments will be made available to the public. Warning: Please do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments are posted on the Internet exactly as received and can be retrieved by most Internet search engines. No deletions, modifications, or redactions will be made to the comments received, as they are public records. Comments may be submitted anonymously.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the “Submit a comment” instructions.

2. *By regular mail.* You may mail written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9942–NC, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9942–NC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments only to the following addresses prior to the close of the comment period:

- a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available

for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Beth Baum or Amy Turner, Employee Benefits Security Administration, Department of Labor, at (202) 693–8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 317–6846; Cam Moultrie Clemmons, Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, at (410) 786–1565.

Customer Service Information: Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws may call the EBSA Toll-Free Hotline at 1–866–444–EBSA (3272) or visit the Department of Labor’s Web site (<http://www.dol.gov/ebsa>). In addition, information from HHS on private health insurance for consumers can be found on the CMS Web site (www.cciio.cms.gov), and information on health reform can be found at <http://www.HealthCare.gov>.

SUPPLEMENTARY INFORMATION:

I. Background

Section 2706(a) of the Public Health Service Act (PHS Act),¹ as added by section 1201 of 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.” Section 2706(a) of the PHS Act 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 section 2706(a) of the PHS Act prevents “a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.”

On April 29, 2013, the Departments issued a Frequently Asked Question (FAQ),² that states that section 2706(a) of the PHS Act is applicable to non-grandfathered group health plans and health insurance issuers offering group or individual coverage for plan years (in the individual market, policy years) beginning on or after January 1, 2014 and stated that until further guidance is issued, plans and issuers are expected to implement the requirements of section 2706(a) of the PHS Act using a good faith, reasonable interpretation of the law. The FAQ states that, 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. The FAQ also states that section 2706(a) of the PHS Act does not require plans or issuers to accept all types of providers into a network and also does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.

The Senate Committee on Appropriations Report dated July 11, 2013 (to accompany S. 1284)³ states that section 2706 of the PHS Act “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 the 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 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.”⁴

II. Solicitation of Comments

Pursuant to this report, the Departments are requesting comments on all aspects of the interpretation of section 2706(a) of the PHS Act. This includes but is not limited to comments on access, costs, other federal and state laws, and feasibility.

Signed at Washington, DC, this 6th day of March, 2014.

Victoria A. Judson,

Division Counsel/Associate Chief Counsel, Tax Exempt and Government Entities, Internal Revenue Service, Department of the Treasury.

Signed at Washington, DC, this 6th day of March, 2014.

George H. Bostick,

Benefits Tax Counsel, Department of the Treasury.

Signed this 5th day of March 2014.

Phyllis C. Borzi,

Assistant Secretary, Employee Benefits Security Administration, Department of Labor.

Dated: March 6, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Dated: March 6, 2014.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

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¹ PHS Act section 2706(a) also is incorporated into section 715(a)(1) of the Employee Retiree Income Security Act (ERISA) and section 9815(a)(1) of the Internal Revenue Code (the Code). Accordingly, the Departments have concurrent jurisdiction over the implementation of PHS Act section 2706(a).

² See FAQs about Affordable Care Act Implementation Part XV, available at <http://www.dol.gov/ebsa/faqs/faq-aca15.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html.

³ S. Rep. No. 113–71, at 126 (2013).

⁴ S. Rep. No. 113–71, at 126 (2013). Additionally, in Title I of the report, regarding the Department of Labor Employee Benefits Security Administration, the Committee “directs the Department to work with HHS and the Department of the Treasury to revise their joint FAQ regarding section 2706 of the ACA, as explained in the HHS title of this report.” S. Rep. No. 113–71, at 27 (2013).