



**American Hospital
Association**

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October 31, 2011

Donald Berwick, M.D., M.P.P.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

RE: CMS-9989-P; Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Proposed Rule (Vol. 76, No. 136), July 15, 2011

Dear Dr. Berwick:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations and our 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule that outlines the requirements and minimum standards for the establishment of state-level Affordable Health Insurance Exchanges (exchanges) and qualified health plans (QHPs).

The exchanges created by the *Patient Protection and Affordable Care Act (ACA)* will serve as marketplaces to not only expand consumers' access to health insurance coverage, but also allow consumers to choose health plans that fit their needs. To ensure the exchanges will promote an efficient operation of a marketplace, the AHA believes that proper regulatory guidance and support from the federal government are essential. The AHA participated in the public process to develop the implementing exchange rules by working with the National Association of Insurance Commissioners and the Department of Health and Human Services (HHS) through its request for comments. The AHA urged that implementing guidance should promote exchanges that are:

- flexible enough to accommodate local conditions;
- user-friendly for consumers;
- efficient to attract private insurer participation while balancing key objectives of pooling risk and managing public subsidies; and
- small in focus, initially, with only the basic elements needed to allow the marketplace to develop.



The AHA is very encouraged by CMS's approach in this initial implementing rule, and we generally support the proposed level of flexibility given to states to create and operate their exchanges. However, our main concern is that the provider network adequacy standards for QHPs are not sufficient; our comments include recommendations to improve the network standards and hold QHPs more publicly accountable.

QHP CERTIFICATION AND PROVIDER NETWORK ADEQUACY

The AHA believes that the network adequacy requirements should be expanded. The criteria for network adequacy need to be clear, measurable parameters that reflect the population and the region. The criteria need to ensure not only the participation of a sufficient number, mix and geographic distribution of providers, but to also ensure that consumers actually have access to providers.

The proposed rule grants states flexibility in establishing QHP standards. States can establish the number and types of plans offered in the exchange and, in working with their state insurance departments, states can set standards for consumer choice, network adequacy and marketing. Beyond codifying the ACA requirements, the proposed rule is sparse on provider network requirements for QHPs.

The AHA urges that the network adequacy requirements be expanded in the following ways.

- ***Sufficient Numbers and Types of Providers and Geographic Proximity:*** The AHA recommends that there be a mechanism to ensure that a health plan not only has an adequate network, but that the network demonstrates sufficient capacity to accept new patients, both initially and throughout the plan year. Health plans need to prove that consumers will be able to access necessary services at a reasonable distance and in a reasonable time to address their particular health care needs. The criteria could include requiring health plans to submit an analysis of their encounter data (which must be submitted for purposes of calculating risk adjustment of health plan rates) to evaluate whether enrollees, especially new enrollees, receive services without having to travel unreasonable distances to do so. Another means to ensure access is to survey new enrollees at the end of their first year to determine if they had difficulty accessing care.
- ***Monitoring:*** The AHA recommends regular monitoring to ensure that plans are not operating “shadow” networks (networks that promise access to providers but where the providers cannot or will not accept new patients). Additionally, health plans should be required to demonstrate that they have the capability to process claims payment for their entire network, and pay providers promptly and accurately. **The AHA believes that the HHS Secretary should use the Medicare Advantage network adequacy standards as a starting point for establishing criteria** while carefully reviewing current Medicare Advantage network problems that include “shadow” networks,

untimely and inadequate claims payment and overly generous mileage requirements for access to providers. **We also recommend reviewing approaches taken by some of the states.** For example, Missouri allows health plans some flexibility in how they achieve required objectives. But the health plans also must demonstrate in their applications how they will meet those objectives and then produce analyses highlighting how well they met the objectives.

- ***Special Consideration for Providers Serving Patients from Multiple States:*** Many hospitals, because of their specific mission and/or location, serve patients who reside outside their state. **The AHA recommends that CMS carefully consider the special role these hospitals play and their unique circumstances when establishing provider network standards for QHPs.**
- ***Process for Payment of Services by Out-of-Network Providers:*** **The AHA recommends that QHPs' network standards must require QHPs to clearly articulate the process by which they will pay for services provided by out-of-network providers.** The AHA further recommends that exchanges carefully monitor the volume and proportion of health care services received by enrollees of a QHP that are provided by out-of-network providers.

QHP Essential Community Providers

The AHA believes that exchanges should have flexibility to develop criteria regarding QHP provider networks and the inclusion of essential community providers. The criteria for essential community providers should not be limited by provider ownership status, eligibility in the 340B drug discount program, Medicare Disproportionate Share Hospital (DSH) status or academic medical center status. The ACA states that the HHS Secretary should instruct, at a minimum, QHPs to include a sufficient number of providers that meet the eligibility criteria for the 340B program and the Medicare DSH adjustment percentage as essential community providers in their provider networks. The ACA does not preclude the HHS Secretary or the exchange from expanding upon this minimum to include other community providers that serve a safety-net function the criterion.

Paramount in the designation of essential community providers should be the needs of the vulnerable populations. Many hospitals, because of their proximity to vulnerable populations or because of their mission, have long served as the safety-net providers for these populations. The exchange is in the best position to determine how to ensure that these populations continue to have access to the health care services they need. Therefore, the definition of essential community provider should be broad enough to accommodate the unique needs of the patient population served by the exchange and the QHPs. The final rule should clarify that states and exchanges have the flexibility to expand the criterion of essential community providers.

QHP Provider Directory

The AHA believes that *potential* enrollees, or at the very least the exchange navigators, should have access to the QHP's provider directory prior to enrollment. As it stands, the proposed rule requires the QHP to make available to the exchange an electronic version of its provider network directory and make a hard copy available to *enrollees* upon request. The QHP's provider directory must list and identify those network providers not currently accepting new patients. The AHA believes that the consumer can make a more informed choice of plans if they know in advance of enrollment which providers are in the plan's network, which network providers are accepting new patients and which providers are not in the network.

Non-Renewal and Decertification of QHPs

The AHA recommends that the exchange give providers notice when QHPs do not seek certification renewal or are decertified. The proposed rule spells out the exchange requirements regarding notification to enrollees when a QHP does not seek recertification or is decertified. Providers will have no way of knowing when a QHP is no longer certified until they submit claims for payment. Notifying providers, particularly hospitals, will enable hospitals to better assist patients that were covered by a decertified QHP to get connected to other forms of health coverage through the exchange.

Marketing of QHPs

The AHA recommends that, in addition to state market conduct rules, federal standards should be adopted to ensure that QHPs do not engage in "red-lining" or exclusionary practices. The proposed rule only requires that QHPs adhere to state laws regarding marketing. Federal marketing standards should also apply to QHPs to guard against the misrepresentation of benefits, conditions for coverage, exclusions and coverage limitations of a QHP for vulnerable populations.

GOVERNANCE AND STAKEHOLDER CONSULTATION

The AHA strongly supports the proposed rule's provisions that allow health care provider participation in exchange governance as well as in stakeholder consultation. CMS proposes that states can include health care providers as voting members on the exchange board. The rule also includes health care providers in the list of stakeholder groups with which exchanges must consult on an ongoing basis regarding the operations of the exchange. These are important additions to the ACA requirements and allow providers to share their expertise and contribute constructively to the design and direction of the health insurance exchanges.

GENERAL STANDARDS AND FEDERAL EXCHANGES

The AHA supports the flexibility in the proposed rule to allow states to seek conditional approval status as well as explore partnership arrangements with the federal government as they attempt to establish exchanges within their states. The proposed rule allows the HHS Secretary to grant conditional approval of a state's exchange in January 2013 if that state makes significant progress toward having the exchange operational by January 1, 2014. The rule also proposes a federal-state partnership option where the state could establish the exchange and perform some of the functions with the federal government providing other functions, such as the Internet technology platform for comparative data on plans or online enrollment. This added flexibility may enable more states to more quickly move toward fully implementing health insurance exchanges.

In the case where a state will not have a functioning exchange ready by January 1, 2014, the ACA instructs the HHS Secretary to establish a federal exchange. The proposed rule and the subsequent state listening sessions conducted by CMS have provided little detail on what a federal exchange would look like. The proposed rule does suggest that further guidance will be forthcoming. **The AHA strongly recommends that any guidance on a federal exchange be sensitive to the unique health care needs of a state's population as well as the characteristics of the state's insurance market. The AHA further encourages the HHS Secretary, when considering guidance on federal exchanges and regional exchanges (multi-state exchanges), to pay special attention to health care providers, in particular hospitals, that because of their mission and locality may serve patients from multiple states with different exchanges and QHPs.**

The AHA is a strong advocate for viable, functioning health insurance exchanges. We look forward to working with you and your staff to continue to meet this objective. As CMS moves forward with the exchange regulation, we urge the agency not to confuse the purpose of the exchange – to create an efficient private insurance marketplace for insurance carriers and consumers – with large scale regulation of the health care marketplace.

If you have any questions about our comments, please contact Molly Collins Offner, policy director, at mcollins@aha.org or (202) 626-2326, or Ellen Pryga, policy director, at epryga@aha.org or (202) 626-2267.

Sincerely,

/s/

Rick Pollack
Executive Vice President