American Hospital Association

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July 19, 2013

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS 9995-IFC3 Pre-Existing Condition Insurance Plan Program; Interim Final Rule (Vol. 78, No. 99, May 22, 2013)

Dear Ms. Tavenner:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) interim final rule implementing provider payment rates for the remaining months of the pre-existing condition insurance plan (PCIP) created by the *Patient Protection and Affordable Care Act* (ACA).

The ACA established a temporary high-risk insurance program to provide health insurance coverage to eligible uninsured individuals with pre-existing conditions. The program took effect June 21, 2010 and will end Jan. 1, 2014. The AHA has supported the PCIP program because it created a temporary access bridge for seriously ill individuals denied affordable coverage until all health plans will be prohibited from imposing pre-existing condition limitations in their policies. Our member hospitals also assisted with communicating about the availability of the program in its early years to their communities.

However, the program is now running out of its appropriated funds sooner than expected, and CMS is reducing payments to providers in an attempt to stretch the remaining funds to the end of the year. **The AHA is disappointed that the rate reduction was issued without input from the provider community and did not provide a sufficient definition of the rate that will be paid to providers. We believe this will lead to confusion during these remaining months of the program.**

CMS bases the PCIP program's new payment rates predominantly on "100 percent Medicare rates," with limited exceptions, such as prescription drugs, organ/tissue transplantation, dialysis and durable medical equipment. Where a Medicare payment rate cannot be readily implemented by the federally administered PCIP, CMS will make payment on the basis of 50 percent of billed charges or using a relative value scale pricing methodology. CMS also prohibits balance billing.

While the preamble to the rule describes CMS's intent to adopt these payment rates because they are familiar to providers, simply referring to "100 percent of Medicare payment rates" is not adequately clear and raises many question as to what is included in these rates. For example, this reference does not address whether the many adjustments that are made to Medicare rates, such as indirect medical education and disproportionate share hospital payments, are included.

The AHA believes the simplest way to remedy this problem would be to base payment on the current Medicare Advantage out-of-network provider payment guidelines most recently updated in December 2012. While we believe there are some issues with those guidelines, the limited time remaining under the PCIP program does not warrant development of a new set of guidelines. Furthermore, providers are familiar with those guidelines, which include discussion of the various adjustments that might apply and address the payment basis for each provider type.

Thank you for your consideration of our comments. We look forward to working with you and your staff on the further implementation of the ACA. If you have any questions, please contact me, Ellen Pryga, policy director, at (202) 626-2267 or epryga@aha.org, or Molly Collins Offner, director of policy development, at (202) 626-2326 or mcollins@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President