American Hospital Association

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February 25, 2014

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 Draft 2015 Letter to Issuers in the Federally-facilitated Marketplaces

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) Draft 2015 Letter to Issuers in the Federally-facilitated Marketplaces. This letter presents several operational and technical modifications to the guidance for participation in the Federally-facilitated Marketplace (FFM) and the Federally-facilitated Small Business Health Options Program (SHOP). The letter also addresses several areas of importance to hospitals, including network adequacy and essential community providers. Our comments pertain to both of these areas with regard to certification of Qualified Health Plans (QHPs) to be offered in the marketplaces in 2015.

Network adequacy is a significant issue for patients and providers. **The AHA believes it is important to ensure that enrollees have access to a selection of high-quality providers in or near to their communities, while not inhibiting care coordination and the growth of integrated care systems**. Integrated care systems, by their nature, offer narrower networks of highly integrated providers who coordinate multiple aspects of care delivery in a defined geographic area and use a common electronic health record.

Our detailed comments follow by corresponding subsection of the letter.

CHAPTER 2. SECTION 3. NETWORK ADEQUACY

The AHA commends CMS for proposing to require QHP applicants, beginning in 2015, to submit for review a provider list that includes all in-network providers and facilities. We are pleased to see that CMS is taking a more direct role in reviewing QHP networks and no longer relying on proxies, such as health plan accreditation status or health plan attestations, regarding network adequacy. We also appreciate that CMS will devote attention to adequacy of specific provider categories that include hospital systems, as well as mental health, oncology and primary care providers.

The AHA appreciates that CMS will utilize the experience gained in the 2015 QHP certification process to study QHP network development and potentially develop specific network adequacy guidelines for the 2016 QHP certification process. However, we ask that CMS define with greater specificity "reasonable" network coverage and the standards the agency will use to determine if a network is, or is not, determined to be "reasonable." By doing this, CMS will ensure that networks are consistently constructed, enrollee and provider confusion is minimized, and the development and certification processes are streamlined and timely.

The AHA recommends that CMS provide greater specificity in the final 2014 Letter to Issuers, or in other 2014 guidance, the criteria that CMS will use to determine "reasonableness" for 2015 QHP networks. These might include one or more of the following:

- Time and/or distance to in-network providers of essential health benefits;
- Average wait times between appointment scheduling and being seen by in-network providers; or
- Availability of in-network providers accepting new patients.

The AHA also strongly recommends that CMS establish limitations on network changes so that significant QHP network reductions are not happening after the start of the annual enrollment period or during the plan year. It is simply not acceptable for QHPs to reduce their networks during or after the enrollee selection period, as that causes great confusion for the enrollee and the provider. For those with chronic conditions, losing in-network providers can result in serious damage to their care plans and continuity of care. This can ultimately result in greater out-of-pocket expense at the point of service and can cause hardship for enrollees, especially among those with low-incomes. With few exceptions, significant changes, such as the elimination of hospitals, essential community providers and major physician groups, should be limited to the time preceding certification of the QHP. In the event of an approved exception, the removal of a significant provider facility or practice should require at least 90 days-notice and a continuity of care plan, as well as potentially triggering a Special Election Period. Exceptions should be limited to provider retirements or other extenuating market circumstances, and require evidence that a reasonable effort was made to retain the provider through the QHP plan year.

CHAPTER 2. SECTION 4. ESSENTIAL COMMUNITY PROVIDERS (ECPs)

The AHA commends CMS for proposing rulemaking that will ensure greater participation in 2015 QHPs by ECPs. In particular, the AHA supports that a minimum of 30 percent of the available ECPs in the plan's service area participate in the provider network. We also support removing the minimum exception standard for ECPs in 2015. Finally, the AHA is pleased to see that, in addition to the 30 percent rule above, CMS proposes to require QHPs to offer a contract in good faith to at least one ECP provider in each of the ECP categories (CMS Table 2.1 on Page 24 of the Letter and below) in each county in the service area, where an ECP in that category is available. In the event that there is a sizable concentration of low-income individuals in a county, CMS should consider requiring a good faith contract be offered to additional ECPs in each of the same categories, subject to availability.

Table 2.1: ECP Categories and Types in FFMs

Major ECP Category	ECP Provider Types
Federally Qualified Health Center (FQHC)	FQHC and FQHC "Look-Alike" Clinics, Outpatient health programs/facilities operated by Indian tribes, tribal organizations, programs operated by Urban Indian Organizations
Ryan White Providers	Ryan White HIV/AIDS Providers
Family Planning Provider	Title X Family Planning Clinics and Title X "Look-Alike" Family Planning Clinics
Indian Health Providers	Indian tribes, Tribal and Urban Indian Organization Providers
Hospitals	Disproportionate Share Hospital (DSH) and DSH-eligible Hospitals, Children's Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals
Other ECP Providers	Sexually Transmitted Disease Clinics, Tuberculosis Clinics, Hemophilia Treatment Centers, Black Lung Clinics, and other entities that serve predominantly low-income, medically underserved individuals

The AHA also supports the continuation of the alternate ECP standard for issuers that demonstrate that a majority of covered professional services are provided through employed physicians or through a single contracted medical group. This ensures reasonable and timely access for low-income, medically underserved individuals in the QHP service area in accordance with marketplace network adequacy standards. This provision allows for the development and growth of integrated systems of care while ensuring that appropriate access is available to vulnerable populations.

Thank you for your consideration of our comments. We look forward to working with you and your staff on subsequent ACA rule making. If you have any questions, please contact Jeff Goldman, vice president of coverage policy, at (202) 626-4639 or jgoldman@aha.org or Ellen Pryga, director of policy, at (202) 626-2667 or epryga@aha.org.

Sincerely,

/s/

Linda E. Fishman
Senior Vice President, Public Policy Analysis & Development