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January 15, 2016

Kevin Counihan
Director & Marketplace Chief Executive Officer
Center for Consumer and Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces (Center for Consumer and Information and Insurance Oversight Memo dated December 23, 2015)

Dear Mr. Counihan:

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 2017 Letter to Issuers, which provides technical and operational guidance to those wishing to offer qualified health plans (QHPs) in the federally-facilitated marketplaces (FFMs). The draft Letter to Issuers also reflects additional guidance on standards included in CMS's proposed rule, titled "HHS Notice of Benefit and Payment Parameters (NBPP) for 2017."

The AHA previously [commented](#) on the proposed rule and focused on a number of issues including network adequacy, acceptance of third-party payments by QHPs, essential health benefits, consumer assistance programs, medical loss ratio, enrollment, changes to patient safety standards and payment parameters, such as risk adjustment, reinsurance and risk corridors.

Our comments on the draft Letter to Issuers will focus more narrowly on network adequacy standards for time, distance and transparency; acceptance of third-party payments by qualified health plans; and changes to patient safety standards.



CHAPTER 2: QUALIFIED HEALTH PLAN STANDARDS

Section 3. Network Adequacy Standard (iii) Federal Default Standard Time and Distance.

The AHA supports CMS's efforts to strengthen QHP provider networks by proposing new network adequacy standards, such as time and distance requirements. While the AHA generally supports the use of time and distance standards for provider networks similar to standards used by the Medicare Advantage (MA) program, we encourage CMS to allow for the special circumstances and unique medical needs of children and adults with complex and chronic medical conditions. These complex patients may need more immediate and frequent access to certain specialty providers than is accommodated by a uniform time and distance standard.

In addition, the proposed guidance is not sufficiently inclusive to cover the specialists needed in treating those with complex and chronic medical needs. As such, the only specialty area listed for children is pediatrics, which is a broad and general specialty covering care from birth through adolescence. For example, the guidance proposes for large metro areas for the pediatric specialty a time and distance standard that would require that 90 percent of enrollees must have at least one provider within 15 miles or 30 minutes. A pediatric patient with complex medical needs may have access to a general pediatrician but may not have access to needed specialists. CMS may need to consider a wider range of pediatric specialties, such as pediatric cardiologists or pulmonologists, for this network adequacy metric to truly meet the needs of children with chronic and complex health care needs.

A similar argument can be made for older adults with chronic or complex medical conditions. The list of specialists in the proposed guidance does not include geriatrics. Again, we suggest that CMS may need to consider a wider list of specialists serving adults with chronic or complex medical conditions for this network adequacy standard.

Section 3. Network Adequacy Standard (v) Network Transparency. The proposed guidance outlines a general framework that CMS is contemplating to determine and publicly post the breadth of the QHP's network based on the type of specific providers and facilities highly utilized by QHP enrollees. **In general, the AHA supports this proposal to provide more transparent information about the breadth of a QHP's network. We would, however, urge CMS to consider including in its analysis of a QHP the types of specialists that treat patients with complex medical and chronic conditions.** They may not be highly utilized but are, nonetheless, an important consideration in the determination of the breadth of a QHP's networks.

Section 6. Patient Safety Standards for QHP Issuers. **The AHA urges CMS to provide flexibility with regard to the timeline for compliance with the patient safety standards.** In the draft Letter to Issuers, CMS envisions that QHP issuers would collect information from applicable hospitals to demonstrate compliance with new patient safety standards proposed in the 2017 NBPP. We generally supported CMS's patient safety proposals in the NBPP rule and believe it is important for hospitals to engage in

initiatives in which they collect and analyze data, implement evidence-based solutions, track progress and encourage a culture of safety. We do not yet know how CMS will finalize its proposals in the NBPP rule, but we expect the agency will require hospitals to partner with one of several designated types of patient safety improvement organizations. Thus, CMS will likely give hospitals several compliance options from which they may choose. For example, hospitals may be able to comply with the new standards by having an agreement with a patient safety organization (PSO), Quality Improvement Organization (QIO) or Hospital Engagement Network (HEN). **Hospitals should have a year from the date the NBPP rule is finalized to ensure that the arrangements to comply with the new standards are in place. This would mean that data on compliance would likely not be available for the QHP issuers to collect until 2018.**

The AHA asks for this flexibility for two reasons. First, hospitals that are not already part of a PSO, HEN, QIO or other organization CMS may designate would need ample time to determine which option they should choose to comply. That decision process will likely include: (1) researching the available options in their regions; (2) evaluating the options for their potential benefits and value, which includes obtaining feedback from staff and departments that will be involved in the initiative, examining whether new technology will be needed and at what cost, and so forth; and (3) negotiating the agreements with the chosen patient safety improvement organization. If the final NBPP rule is released in February, and negotiations between hospitals and QHP issuers take place in the spring and summer, hospitals will have very little time to set up agreements with patient safety improvement organizations before the QHP issuers must submit to CMS their health plans for approval and certification.

Second, flexibility is needed because quality improvement projects, such as those coordinated by QIOs, may have specific enrollment periods. A hospital may need to wait for a new enrollment period that begins after the 2017 plan year negotiations with QHP issuers. Alternatively, hospitals may need time to obtain permission to join an initiative already in progress.

We urge CMS *not* to create incentives for hospitals to rush into agreements with improvement organizations simply for the purpose of meeting QHP issuer negotiation deadlines. Hospitals need flexibility to target their resources to initiatives that address identified patient safety issues that are priorities for their organization.

Section 13: Third-Party Payment of Premiums and Cost-Sharing. **The AHA continues to urge CMS in its 2017 NBPP final rule and final Letter to Issuers for 2017 to require QHPs to accept third-party premium and cost-sharing payments from hospitals, hospital-affiliated foundations and other charitable organizations, just as they are required to accept these payments from the Ryan White HIV/AIDS program.** Any effort to limit the ability of hospitals or hospital-affiliated foundations and other charitable organizations to help needy individuals obtain access to health insurance coverage is inappropriate. Not only does it undermine one of the core objectives of the Affordable Care Act (ACA) – making affordable insurance coverage available to the uninsured – it also adversely impacts those who need it most: the poor and sick. The

entire marketplace approach is based on the notion that any individual (with limited exceptions) can choose to purchase any QHP offered through an exchange. As long as the premium for that plan is paid, the insurer has to accept that individual and enroll him or her in the chosen plan (again, with limited exceptions). As in any other commercial market, it should not matter who actually pays the insurance premium – the enrollee, the enrollee’s relative or another person or organization. The AHA and its members will continue to work to enable as many Americans as possible to obtain health care coverage, especially those with limited resources who have no other means of coverage. As such, we urge CMS to remove the impediments it has created for hospitals to achieve that goal.

The AHA supports strong and viable health insurance marketplaces to help achieve the coverage goals of the ACA. CMS’s Letter to Issuers is an important mechanism to ensure QHP marketplace qualifying standards are met. The AHA urges CMS to consider our recommended changes to the draft Letter to Issuers regarding network adequacy standards, acceptance of third-party payments by QHPs and changes to patient safety standards.

Thank you for your consideration of our comments. If you have any questions, please contact Molly Collins Offner, director of policy development, at (202) 626-2326 or mcollins@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development