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Via Electronic Submission (FFEcomments@cms.hhs.gov**)**

March 15, 2013

Mr. Gary Cohen
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight (CCIIO)
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Letter to Issuers on Federally-facilitated and State Partnership Exchanges

Dear Mr. Cohen:

The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) draft Letter to Issuers on the Federally-facilitated and State Partnership Exchanges (Letter). The AAMC represents all 141 accredited U.S. medical schools, nearly 400 major teaching hospitals and health systems, and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 125,000 faculty members, 75,000 medical students, and 106,000 resident physicians who deliver over one-fifth of all clinical care in the nation.

The AAMC recognizes the extraordinary efforts and coordination needed to implement the Affordable Care Act's (ACA's) health insurance marketplace reform provisions and to make the health insurance exchanges (Exchanges), including the Federally-facilitated Exchanges (FFE), Federally-facilitated SHOPs (FF-SHOP), and State Partnership Exchanges operational by 2014. While the Association is acutely aware of the urgency and complexity of short-term implementation issues, we encourage CMS to carefully consider long-term policy implications and the role that the Exchanges will play in reshaping the insurance market.

Our comments on this guidance focus on network adequacy and Essential Community Provider (ECP standards) and ensuring that these standards adequately protect Exchange participants from being denied access to lifesaving care that in many cases only teaching hospitals can provide. Teaching hospitals serve a unique and critical role as sole providers of highly specialized tertiary

care unavailable elsewhere, such as burn care, trauma, and transplant services. These institutions are also responsible for training all types of health care professionals necessary to meet our society's health care workforce needs. As the insurance marketplace evolves through the availability of the ACA's new coverage options, it is critical for CMS to set standards that will protect graduate medical education and access to the public goods that teaching hospitals provide by making advanced technologies and clinical expertise available to the nation's sickest, most complex, and most vulnerable patients.

SECTION 1. NETWORK ADEQUACY AND INCLUSION OF ESSENTIAL COMMUNITY PROVIDERS

AAMC's comments on this guidance focus on how CMS will review health plans applying as qualified health plans (QHPs) for compliance with network adequacy and Essential Community Provider (ECP) standards. It is critical that patient access to America's teaching hospitals is not restricted through the exclusion of these institutions from participation in Exchanges due to costs associated with their clinical care, education, and research missions. The federal government must carefully consider how the mission-related costs that are not supported by Medicare will be covered as Exchanges become operational.

The Association is particularly concerned that CMS' guidance for compliance with network adequacy and ECP standards will not prohibit the development of tiered plan networks that could make teaching hospitals inaccessible to Exchange participants. This could disproportionately affect low-income individuals who would have to forgo lifesaving care due to prohibitive copays or coinsurance. The AAMC's teaching hospital members, also known as the Council of Teaching Hospitals and Health Systems (COTH) account for just six percent of all hospitals yet provide a disproportionately large amount of care to Medicaid and uninsured patients. Teaching hospitals perform 97% of bone marrow transplants, 98% of kidney transplants, 80% of level 1 trauma and burn beds, and are often the only regional provider of such care.[1] If network adequacy and ECP standards are not sufficiently robust and are not enforced in a manner that continues to allow individuals newly insured through the Exchanges access to inpatient and outpatient care, preventive services, and the critical around-the-clock specialized services that teaching hospitals provide, this cannot be considered meaningful health care reform.

The Letter indicates that QHPs should view the network adequacy and ECP standards set forth in 45 CFR §§ 156.230 and 156.235 as minimum requirements. These standards will require that a QHP issuer maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible without unreasonable delay. CMS will rely on any states viewed to have sufficient network adequacy reviews to monitor compliance with network adequacy standards. Otherwise, CMS will accept an issuer's accreditation, either commercial or Medicaid, or the issuer can submit an access plan to the Agency. The lack of specificity in the proposed safe harbor standard and minimum expectation, the reliance on varied state assessments, and the exception to network adequacy rules for single contracted products create enough ambiguity

[1] HCUP Nationwide Inpatient Sample (NIS), 2010, Agency for Healthcare Research and Quality (AHRQ), based on data collected by individual States and provided to AHRQ by the States.

about requirements to raise our concern that plans could exclude teaching hospitals from their networks.

Only requiring issuers to demonstrate that 20 percent of ECPs in the plan's service area participate in the issuer's provider network (and only one in each ECP category per county) to meet the safe harbor standard does not ensure that enrollees will have access to academic medical centers (AMCs) for their care. Even more concerning is the minimum expectation for plans, which allows an issuer to submit an application demonstrating that 10 percent of the available ECPs in the service area participate in the provider network along with a narrative justification of how this network will provide adequate level of service for low income and medically underserved enrollees.

AAMC firmly believes that a QHP's network should include a range of providers in a community and ensure enrollee access to the most appropriate source of care. The guidelines issuers must comply with to offer products on the Exchanges should not allow plans to exclude institutions that legitimately incur higher costs to support graduate medical education, treat more complex and lower income patients, and provide specialized services and lifesaving care that no other institutions can provide. Since teaching hospitals have a range of care options that are not available at most non-teaching hospitals, the standards should ensure in-network access to an academic medical center to meet the safe harbor standard. Additionally, if an issuer submits a narrative justification, the issuer should be required to explain how enrollees will have timely access to specialized services such as transplants, burn units, and trauma centers that generally only teaching hospitals provide.

As CMS develops guidance to ensure access through compliance with network adequacy and ECP standards, AAMC strongly urges the Agency to make sure that this guidance does not allow cost to become a driver of network design, which could prevent Exchange enrollees from accessing teaching hospitals because of the costs associated with the unique societal missions they support. If strong standards for network adequacy are not set and enforced early on as Exchanges are established, changes in the insurance marketplace could put teaching hospitals out of reach for whole segments of the population.

Clear network adequacy requirements need to be reinforced with quality standards that will ensure that plans do not sacrifice quality for the sake of initially providing lower premiums. The Association encourages CMS to consider the fact that quality care decreases costs in the long run. For example, recent studies show that higher quality surgery actually lowers costs because costly complications can be avoided by providing improved care. CMS' guidance should include standards to prevent QHP issuers from creating narrow networks and solely prioritizing lower premiums, with no consideration of the affect on the quality of the providers in network or on compensation for graduate medical education. If the Agency does not establish these standards, the reform of the insurance marketplace could deny millions of individuals access to the specialized lifesaving services that teaching hospitals provide and at the same time jeopardize the funding necessary to train enough doctors to care for a growing insured population. AAMC would welcome the opportunity to work with CMS to ensure that we can train the next

generation of physicians to meet the country's health care needs and to continue to provide critical health care services to all Americans, including those who participate in the Exchanges.

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The AAMC appreciates this opportunity to provide comments on this Letter. If you have questions, please contact me at jconroy@aamc.org or Allison Cohen, Senior Policy and Regulatory Specialist at acohen@aamc.org. We both also may be reached at 202-828-0490.

Sincerely,

/s/

Joanne M. Conroy, M.D.
Chief Health Care Officer
AAMC

cc: Allison Cohen, J.D., L.L.M., AAMC