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Via Electronic Submission (www.regulations.gov)

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Donald M. Berwick, MD, MPP
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Proposed Rule, File Code CMS-9989-P

Dear Administrator Berwick:

The Association of American Medical Colleges (AAMC or the Association) is pleased to comment on the Centers for Medicare and Medicaid Services' (CMS' or the Agency's) proposed rule entitled *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans*. 76 *Fed. Reg.* 41866 (July 15, 2011). The AAMC represents all 135 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. Our comments focus on the proposals relating to network adequacy and essential community providers for the networks established by qualified health plans (QHPs). It is critical that the final rule ensure that patient access to America's teaching hospitals and clinical faculty practice plans is not restricted through the exclusion of these groups from participation in Health Insurance Exchanges (HIEs or Exchanges) and QHPs due to costs associated with their clinical care, education, and research missions. Such a decision is critical to ensuring that newly insured individuals have access to these important providers and that these institutions can continue their important roles within their respective communities.

OVERVIEW

The AAMC appreciates CMS' thoughtful work on developing the framework for Exchanges. The Association is acutely aware of the complex tasks faced by CMS, the States, Exchanges, and private health plans in operationalizing the Exchanges and the other provisions of the Affordable Care Act (ACA) by 2014. The AAMC applauds the Agency's extraordinary efforts to date in implementing these provisions at the same time as it implements complex Medicare and Medicare changes that were included in the ACA.

While the AAMC has great respect for the imperatives of timely State implementation of the Exchanges, the Association strongly believes that CMS must carefully consider the policy impact of the Exchanges and rules for QHPs, thinking not only about the immediate start-up implementation issues, but also about the Exchanges' roles in the permanent reshaping of the insurance market. However they are fashioned, HIEs will not just be passive participants in health care, but direct and indirect shapers of health care in communities for years to come. The rules ultimately set for participating QHPs will have a significant impact on the financing and delivery of care for the millions of Americans who will receive coverage through the Exchanges, as the ACA is projected to reduce the number of uninsured Americans by about 32 million by 2016, and there will be over 20 million Exchange enrollees by that year¹. Consequently, we believe that CMS must craft this final HIE rule, and other associated rules, in the context of the broader policy imperatives set out in the ACA. It is the breadth of the policy direction in the ACA that presents both difficult implementation timetables and the greatest health reform opportunity. At the outset of Exchange implementation, it is necessary to craft consistent policies across all of the proposed rules that address in a coherent manner, with common incentives and directions, the priorities ranging from coverage and insurance reform to delivery reform, cost constraint, quality improvement, access, and health professions education.

As the regulations' formats for HIEs and QHPs are being developed, it is important that CMS keep in mind the health care providers that will care for Exchange participants. Teaching hospitals and their affiliated clinical physicians are critical to our nation's health care system and the communities where they are located. They often are the regular sources of care for many residents in the community, providing inpatient as well as outpatient care and preventive services. At the same time, teaching hospitals also are the locus for training all types of health care professionals; are the environments in which clinical and health services research flourish; and are where patients receive highly specialized tertiary care unavailable elsewhere, such as burn care, trauma, and transplant services. With residents and supervising physicians available around-the-clock, teaching hospitals also care for the nation's sickest patients. In fact, they often treat complex, vulnerable patients transferred from non-teaching institutions that are unable (or unwilling) to care for them.

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, including 40 percent of hospital charity care and 28 percent of all Medicaid inpatient care. These six percent of hospitals also provide nearly one-fifth of all Medicare discharges. Moreover, many of these Medicare patients are sicker and have more complicated illnesses. The average Medicare case mix index for AAMC COTH hospitals is 1.8, versus 1.6 for other teaching hospitals and 1.4 for non-teaching hospitals².

As a result of these special missions, these institutions have higher costs than other hospitals. The federal government has recognized these higher costs and, through the Medicare program, has implemented policies so that these providers are not unfairly penalized because of the

¹ CBO's March 2011 Baseline: Health Insurance Exchanges, Congressional Budget Office, March 18, 2011.

² AAMC Analysis of IPPS Final Rule Impact File, FY 2012.

important societal missions they fulfill.³ As HIEs are implemented, the AAMC believes it is an appropriate time for the federal government to examine how the costs that are not supported by Medicare are reimbursed.

The AAMC believes it is incumbent on the federal government to insure that Exchanges and QHPs recognize the important contributions of teaching hospitals and teaching physicians in caring for Medicare beneficiaries, Medicaid beneficiaries, and all patients. Teaching hospitals and faculty take on added burdens that consequently benefit their communities, regions, and states as a whole. In developing standards for QHPs, it is essential that these providers are not excluded because of the higher costs associated with their societal missions. Furthermore, the integral role of teaching hospitals and physicians in their communities must be considered when defining network adequacy standards and essential community providers.

NETWORK ADEQUACY AND ESSENTIAL COMMUNITY PROVIDERS

The proposed rule discusses network adequacy standards for QHPs, and the related issue of the definition and inclusion of essential community providers. These standards establish the critical access requirements for QHPs and the providers that care for enrollees, and, in the case of the academic medical centers, the organizations that fulfill national priorities for education and research as well. The AAMC is concerned that the standards as proposed for QHP network adequacy are not well enough defined and potentially are ripe for the development of tiered plan networks that exclude teaching hospitals and faculty physicians from Exchange plans based on these providers being deemed “high cost,” while not accounting for the value added by the other missions and societal benefits AMCs provide. Furthermore, the Association is concerned that the proposed definition of essential community providers does not include AMCs despite their community mission, resulting in decreased access for newly insured Exchange enrollees who have traditionally received care at AMCs.

CMS states in the proposed rule that network adequacy standards should be appropriate to local conditions, and proposes for Exchanges what the Agency describes as a “broad standard,” requiring only that that a QHP must include a provider network with “a sufficient choice of providers for enrollees” (proposed §155.1050) 76 *Fed. Reg.* at 41921 and “a sufficient number of essential community providers, where available, that serve predominately low-income, medically-underserved individuals.” (proposed §156.235) 76 *Fed. Reg.* at 41924. CMS proposes to define essential community providers as including only those groups suggested in the ACA, namely those named in section 340B(a)(4) of the Public Health Service Act and in section 1927(c)(1)(D)(i)(IV) of the Social Security Act. CMS, however, is seeking comment on other provider groups that serve the same communities: low-income, medically underserved populations.

³ The Medicare program makes two payments to help offset the higher costs of teaching hospitals: direct graduate medical education (DGME) and indirect medical education (IME) payments.

Network Adequacy

The AAMC believes that, as proposed, the network adequacy standards are insufficient. Patients who currently rely on AMCs for their care, as AMCs disproportionately care for the uninsured, should be able to continue to receive their care at these institutions once covered by an Exchange plan and should not be penalized by having to enroll in a plan that prevents them from seeing their long-standing providers, or makes those providers prohibitively expensive by imposing high enrollee out-of-network cost sharing. QHPs should reflect the range of providers in a community, insuring enrollee choice and access to the most appropriate source of care.

At the overall insurance level, the ACA takes a number of steps, including underwriting reforms and adjusted community rating, to assure that health coverage is provided without regard to a person's medical condition, and plans do not cherry-pick lower cost individuals. It is essential that QHP network standards reinforce these policies and do not undermine them by allowing networks to be constructed in a manner that discourages access, and thus enrollment, of those with unique or high cost conditions, as a means to lower premiums. Excluding major teaching hospitals altogether from the networks of QHPs, or subjecting them to exceptionally high cost sharing, would reduce access for these medically frail individuals because it is precisely these institutions that treat these patients. This has already been seen within the Medicaid population where, as state reimbursement for Medicaid has decreased, fewer providers are willing to treat Medicaid patients. As a result, these patients are forced to seek care at community safety net institutions, often an AMC.

As has been well documented, the nation faces an acute physician shortage. Coupled with an increased demand for physician services through the influx of newly insured individuals, a physician shortage may profoundly affect access to health care, including longer waits for appointments and the need to travel farther to see a physician. Shortages can also contribute to higher costs through increased use of emergency rooms and decreased use of preventive services. In addition, physician shortages can reduce the quality of care if practitioners are overloaded or if individuals are forced to delay treatment. The ACA sets out several policies to enhance health professions training and dispersion of health professionals to communities that need them. The Medicare program has long-recognized with careful analysis the extra and justifiable costs borne by teaching hospitals as they educate the next generation of needed providers. Furthermore, through their research mission, AMCs are important drivers of medical, scientific, and care delivery innovations that contribute to increased quality and lower cost.

The rules for QHPs and Exchanges should not undermine those policy objectives and provisions by allowing for an exclusion of the providers that incur legitimately higher costs because they respond to these critical societal needs and ACA priorities. It is essential that provisions such as QHP networks standards reinforce rather than undermine the imperative for access in underserved areas.

Essential Community Providers

The AAMC is concerned that, as proposed, the definition of essential community providers is too limited and fails to consider the wide range of providers that offer necessary services to a community that could be excluded if this definition is finalized. AMCs often are the sole provider of highly specialized tertiary and quaternary care services in a community, while also serving as the safety net and regular source of care for low-income, uninsured populations—the very individuals who stand to benefit from the creation of Exchanges. In many cases, teaching hospitals and their affiliated faculty physicians already serve as the essential community providers for these individuals. CMS should not overlook the vital role that these institutions provide and should specify in the final rule that they be deemed essential community providers, so that they are not excluded from QHPs. Failure to do so exacerbates inequity as the newly insured receiving coverage through Exchange QHPs would face limited choices of providers and critically needed specialized services.

Potential for the Development of Tiered Networks

The AAMC is very concerned that the proposed standards for network adequacy and essential community providers could lead to the development of tiered networks, thus limiting enrollee access to AMCs. Based on language included in the proposed rule preamble, the basis for CMS' rationale for plan design is around controlling health care costs. The Agency considered adopting a standard for issuers to contract with all willing providers, but ultimately decides in the proposed rule that "requiring issuers to offer contracts to all essential community providers would allow continuity of service for enrollees with existing relationships especially in communities where the essential community provider has been the only reliable source of care. However, such a requirement may inhibit attempts to use network design to incentivize higher quality, cost effective care by tiering networks and driving volume towards providers that meet certain quality and value goals." 76 *Fed. Reg.* at 41899. The AAMC believes that cost alone is not an appropriate driver for network design, and could either purposely or inadvertently penalize AMCs due to the societal missions they support.

To the extent limited networks are allowed to be offered by QHPs through Exchanges, it is imperative that such policies be accompanied by stringent quality metrics to ensure limited network plans are not sacrificing quality and access for the sake of maintaining low premiums, in part through high cost sharing for providers in different tiers. Quality standards must be in place to insure that Exchange plan enrollees are able to receive care from a suitable supply of specialists with the expertise in the breadth of services that are traditionally offered at AMCs, and which might not otherwise be available within a community.

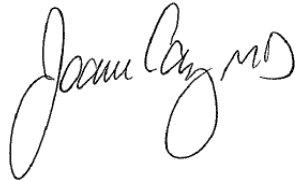
It is also imperative that there be a consistent policy from CMS regarding the recognition of the unique and critical role AMCs play in the nation's health care system. As the training grounds for the much-needed future physician workforce, as well as the safety net providers for the most vulnerable individuals, AMCs are asked to bear extra costs to meet the societal needs of the nation. The network adequacy and essential community provider issues both raise the central policy question of assuring access for all enrollees to needed care, regardless of where they live or of their particular medical condition – those with common conditions and those with rare and

exceptionally complex conditions all need access to care. For example, by limiting networks because of cost, Exchange enrollees that have traditionally sought care at an AMC which serves as their community hospital will be unable to receive care at that setting or will be subject to high out-of-pocket costs. The newly insured should not be unfairly punished based solely on a decision to value lower premiums over enrollee access and choice. In addition to expanding the definition of essential community providers to include AMCs, the AAMC strongly recommends that CMS not prioritize cost to the detriment of care quality and enrollee access and choice.

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The AAMC appreciates the opportunity to comment, and, as always, stands ready to answer any questions about these important issues. We look forward to continuing to work with you in implementing the important provisions of the ACA. If you have any questions concerning these comments, please feel free to contact Jane Eilbacher, Policy and Regulatory Specialist, at jeilbacher@aamc.org or 202-828-0896, or Will Dardani, Clinical Policy and Practice Specialist, at wdardani@aamc.org or 202-828-0541.

Sincerely,



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CC: Jane Eilbacher, AAMC
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