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Submitted electronically via www.regulations.gov.

July 12, 2017

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 9928-NC
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients (RIN 0938-AB39)

Dear Administrator Verma:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's or Agency's) request for information entitled, *Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices To Empower Patients*, 82 *Fed. Reg.* 26885 (June 12, 2017).

The Association of American Medical Colleges is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members comprise all 147 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

The AAMC appreciates CMS's efforts to improve the availability of affordable health insurance coverage in the individual and small group markets by working to reduce regulatory burden. We agree that consumers must have access to high-quality, high-value healthcare providers, and addressing ways to make health insurance more affordable is one way to achieve this goal. However, in order to maintain robust individual and small group marketplaces, consumers must also have access to networks of providers that meet their care needs. The AAMC is concerned that the changes aimed at strengthening the individual market while also attempting to reduce regulatory burden – specifically, relaxing the regulations surrounding network adequacy and essential community providers for qualified health plans (QHPs) – may actually limit consumer

choice and restrict access to providers and, in addition, leave providers who treat these patients either underpaid or not paid at all.

CMS Should Play a Key Role in Ensuring that All States Provide Network Adequacy to Promote Consumer Choice

As finalized by CMS in the market stability final rule[1], beginning with the 2018 plan year, CMS will change its approach to monitoring the network adequacy of plans seeking certification as QHPs. CMS will rely on state reviews for network adequacy in states in which a federally facilitated exchange is operating and where the state has a sufficient network adequacy review process. CMS will require QHPs to maintain the "reasonable access standard" [2] for network adequacy, by relying on states with "the authority and means to assess issuer network adequacy" to determine whether or not a network meets the criteria for adequacy. For those states without the ability to conduct network adequacy reviews, CMS will rely "on an issuer's accreditation (commercial or Medicaid) from an HHS-recognized accrediting entity."[3] These changes supersede the time and distance criteria currently required for QHP certification.[4]

The Need for Robust Networks

In an effort to lower costs, we understand that insurers are eliminating currently offered QHPs that have robust networks of doctors and hospitals and are replacing them with plans with narrow provider networks that limit patients to a select number of providers and decrease access to hospitals that provide specialized care. Limiting provider choice can be particularly detrimental for certain patient groups that need specialized care or already suffer from disproportionate levels of disease and death. In order to make inroads on improving the health and well-being of individuals, meaningful partnerships with local communities are paramount. That includes providing access to high-quality care for patients by ensuring that robust provider networks are offered by issuers in the individual and small group marketplaces. The AAMC is concerned that allowing states to determine the standards for QHP network adequacy has the potential to exclude teaching hospitals and faculty physicians from exchange plans, thereby limiting consumers' choice of provider. This exclusion would be based on these providers being deemed "high cost," without accounting for the value added by the other missions and societal benefits academic medical centers provide.

While representing just 5 percent of the nation's hospitals, America's teaching hospitals provide 35 percent of total hospital charity care in this country. Many of these institutions are safety net providers that care for vulnerable, underserved populations who often cannot seek treatment elsewhere. They are also the hospitals that maintain the vast majority of the country's critical standby units, including trauma centers, burn units, and neonatal and pediatric ICUs, that provide cutting edge treatments to medically complex patients. Compared to other hospitals, major teaching hospitals care for patients that are sicker, poorer, and more likely to be disabled.

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[1] 82 Fed Reg. 18372
[2] 45 CFR 156.230(a)(2)
[3] 82 Fed. Reg. 32 (February 17, 2017)
[4] 2018 Letter to Issuers in the Federally-facilitated Marketplaces (December 16, 2016)

Teaching hospitals are committed to missions of providing critical services, serving vulnerable populations and educating the next generation of physicians. However, these missions carry heavy expenses that are often under reimbursed by payers with these costs being absorbed by the hospitals themselves.

Time and Distance Requirements Are An Impediment to Access

Consumers base their choice of health insurance not only on the providers included in the plan's network but also on the location of those providers. Inability to easily access providers severely limits consumer choice of where they go to seek needed care. We strongly recommend that CMS re-evaluate the need for inclusion of the time and distance criteria in order to promote consumer choice of health insurance and provider. Continuity of care is of particular importance in rural areas that struggle with physician shortages and is often compromised due to the lack of accessible providers. Compounding this problem, is the distance patients must travel in order to seek care from specialists who are usually located at academic medical centers. Allowing insurers to exclude from their networks physicians and institutions solely on the basis that the valuable care they provide is perceived as too costly will only exacerbate the problems of access and lack of care continuity.

The AAMC believes that it is essential that QHP network standards do not undermine the goal of promoting consumer choice 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. Failing to ensure network adequacy often means that major teaching hospitals are excluded from the networks of QHPs due to cost. While excluding a "high-cost" hospital from an issuer's network can work in favor of the issuer, it puts vulnerable patients who may rely on services that only are available at certain hospitals at risk of not receiving the care that is needed.

CMS Should Not Reduce the Standard for Demonstrating a Sufficient Number and Geographic Distribution of Essential Community Providers

CMS finalized its proposal[5] that allows QHP issuers to satisfy the regulatory standard for certification and recertification for the 2018 plan year if the issuer contracts with "at least 20 percent of available essential community providers (ECPs) in each plan's service area to participate in the plan's provider network."[6] In CMS' view, this decrease from the current 30 percent ECP requirement necessary for certification is expected to "substantially lessen" the regulatory burden on issuers. Moreover, CMS stated there will be cost savings as a result of loosening issuer requirements for network size. In its comment letter the AAMC urged CMS to keep the current 30 percent ECP requirement in order to ensure that patients have sufficient access to providers in their communities. The AAMC continues to be concerned that while lessening regulatory burden is a laudatory goal, it should not come at the expense of patients seeking care who will experience increased travel and wait times as a result of the decrease in available providers.

[5] 82 Fed. Reg. 18374
[6] 82 Fed. Reg. 10990-10991

The AAMC remains concerned that this reduction in required ECPs will negatively impact vulnerable populations that rely on academic medical centers for their care. Major teaching hospitals and physician faculty practices serve a disproportionately large volume of underserved, low-income individuals, provide access to essential health services for disadvantaged groups, and are often the last resort for treatment for many. Academic medical centers serve as the backbone of many communities' health care infrastructure. However, in past years, QHP plan issuers have been allowed to exclude these institutions from their networks putting pressure on patients to sever ties with providers with whom they have established doctor-patient relationships or incur financially burdensome cost sharing in order to maintain continuity of care.

CMS Must Take Additional Steps to Account for Sociodemographic Status (SDS) Factors in Hospital Quality Measurement

The AAMC strongly supports the movement from volume to value. Academic medical centers are leaders in the area of providing quality health care, and in creating and implementing innovative care delivery models. The Affordable Care Act (ACA) created the Hospital Readmissions Reduction Program (HRRP) which is intended to reduce Medicare payments to hospitals with excess readmissions, starting with discharges beginning on October 1, 2012. As initially designed, the program lumps all hospitals together, failing to take into account the fact that the patient populations that a hospital treats – for example, patients who are medically complex, and of low sociodemographic status (SDS) – is a key factor in determining whether a readmission is likely.

Most outcome measures, particularly readmission measures, are affected by SDS factors, which are beyond the control of the hospital. The nation's teaching hospitals, which provide superior patient care and disproportionately treat disadvantaged and vulnerable patient populations, are penalized by the performance and penalty programs in part due to the lack of adequate SDS adjustment. Efforts by the National Quality Forum (NQF) to address these important issues through the recently concluded SDS trial period have been underwhelming. And while passage of the 21st Century Cures Act is a good first step in creating a fairer Hospital Readmissions Reduction Program, it is not a panacea. The legislative requirement that the penalty adjustments be budget neutral will only result in slightly reduced penalties for those hospitals most in need of resources to treat underserved and complex patient populations. Most importantly, the Act does not immediately address the serious flaws in the risk adjustment methodology for the readmissions and other outcomes measures that are influenced by SDS.

The literature recognizing the impact of SDS factors on patient outcomes is substantial.[7,8] Recent entities tasked with addressing this issue have also been clear. The reports released by the Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academy of Medicine (NAM) on accounting for social risk

[7] Michael Barnett, MD, et al. Patient Characteristics and Differences in Hospital Readmission Rates. JAMA, 2015. Retrieved from: http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2434813
[8] Jianhui Hu, et al. Socioeconomic status and readmissions: evidence from an urban teaching hospital. Health Affairs, 2014. Retrieved from: http://content.healthaffairs.org/content/33/5/778.full

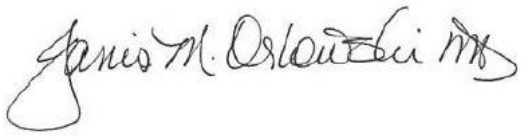
factors in the Medicare performance programs have provided evidence-based confirmation that accounting for patients' sociodemographic and other social risk factors is critical in validly assessing the quality of providers. The reports demonstrate that due to the methodology used, hospitals caring for large numbers of disadvantaged patients are more likely to receive penalties in the performance programs. Further, the lack of SDS adjustment can worsen health care disparities because the penalties divert resources away from hospitals and other providers treating large proportions of vulnerable patients.

The failure to account for SDS variables also can mislead and confuse patients, payers, and policymakers by shielding them from important community factors that contribute to poor health outcomes. Finally, as noted by ASPE, the cumulative effect of the penalties across the Medicare performance and penalty programs could significantly hinder the work of those institutions that disproportionately serve beneficiaries with social risk factors.[9] Both reports clearly show that there are implementable mechanisms by which SDS data elements can be incorporated into quality measurement today. The AAMC urges CMS to account for SDS factors and ensure that all hospitals are assessed on an even playing field.

Conclusion

Thank you for the opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic health center community. If you have questions regarding our comments, please feel free to contact Mary Mullaney at 202.909.2084 or mmullaney@aamc.org.

Sincerely,



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Chief Health Care Officer, AAMC

cc: Ivy Baer, J.D., M.P.H, AAMC
Mary Mullaney, AAMC

[9] "Office of the Assistant Secretary for Planning and Evaluation." Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Program. December, 2016. Pg, 92 Retried from https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf