December 21, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9937-P
P.O. Box 8016,
Baltimore, MD 21244–8016

Re: CMS-9937-P; CMS Notice of Benefit and Payment Parameters for 2017
Submitted via www.regulations.gov

Dear Acting Administrator Slavitt,

Trinity Health appreciates the continued opportunity to provide comments and information regarding the ongoing implementation of health insurance exchanges from the perspective of a large health care system. In this letter, we offer reactions and recommendations related to the Centers for Medicare & Medicaid Services’ (CMS) notice for comment CMS-9937-P, published in the Federal Register on December 2, 2015.

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving more than 30 million people in 21 states. We are building a People-Centered Health System to put the people we serve at the center of every behavior, action and decision. This brings to life our commitment to be a compassionate, transforming and healing presence in our communities. Trinity Health includes 91 hospitals, 126 continuing care programs—including PACE, senior living facilities and home care and hospice services that provide nearly 2.5 million visits annually. Committed to those who are poor and underserved, Trinity Health returns almost $1 billion to our communities annually in the form of charity care and other community benefit programs. We have 27 teaching hospitals with Graduate Medical Education (GME) programs providing training for 1,786 residents and fellows in 174 specialty and subspecialty programs. We employ approximately 95,000 full-time employees, including 3,900 employed physicians, and have over 11,100 physicians and advanced practice professionals committed to 16 Clinically Integrated Networks across the country.

Trinity Health applauds CMS’ efforts to promote the availability of high-quality, affordable health insurance through the federal and state exchanges. Trinity Health is committed to the success of the exchanges, and has created programs and made resources available to help our patients and our communities understand and enroll in health coverage. In the comments that follow, we offer our feedback in the following areas:

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• Network adequacy standards;
• Patient safety standards for QHP issuers;
• Third Party Payment of QHP Premiums;
• State-Based Exchange on the Federal Platform;
• Hierarchy for automatic re-enrollment;
• Annual open enrollment period;
• Standardized plan options;
• Permanent risk adjustment program; and,
• Rate increase disclosure and review.

Network Adequacy Standards

Coordinated networks are critical to achieving high-quality, affordable coverage and better health outcomes. These networks are successful when they balance affordability and network adequacy. Network adequacy standards should focus on three outcomes – better health, better care, and lower costs.

Trinity Health supports consistency and transparency in the development and enforcement of these standards and believes there is a role for both the federal and state government in this process. State insurance commissioners need to be actively engaged in order to best balance cost, access, and geographic considerations when developing appropriate network adequacy standards for qualified health plans (QHPs). Additionally, merely forcing QHPs across all markets to broaden their networks will not guarantee that a consumer’s preferred provider would even be included within a network, or that the consumers’ experience of finding an available provider will be any easier. Ensuring that coordinated networks are kept in place and consumers are making educated decisions is key to overall success.

Trinity Health supports the National Association of Insurance Commissioners (NAIC) and its development of the revised Model Act to establish new standards for network adequacy in the exchanges. However, Trinity Health strongly encourages the use of consistent, quantitative measures to determine network adequacy, and for these measures to be developed in a timely and transparent process. Trinity Health also supports greater transparency regarding the criteria health plans and issuers use to select and tier providers in their network plans. There should, however, be additional, special consideration of these standards in communities – such as urban centers – with many high-risk individuals who do not have the ability to travel. CMS specifically solicited comments and suggestions on state network adequacy methodologies and factors that the Federally-Facilitated Exchange (FFE) could apply to gauge network adequacy. Trinity Health supports uniform and quantitative network adequacy criteria, such as the county classification system used in Medicare Advantage (MA) for states to evaluate as part of their oversight of exchange plans in the FFE as well as the State-Based Exchanges (SBEs). We recommend that CMS apply these proposed standards to not only QHPs sold in the FFE but also to QHPs sold in SBEs. As a health system operating in 21 states, Trinity Health has found that different standards across states creates much inefficiency and is administratively burdensome. Consistency in the development of standards is also important to population health and delivering people-centered care where people are put at the center of every behavior, action and decision.
Continuity of Care Standards

CMS proposed requiring QHP issuers in all FFEs to notify enrollees 30 days prior about discontinuations of contracted providers in their networks. Trinity Health commends CMS for recognizing the importance of patient experience and continuity of care for individuals who experience changes to their network of providers. Trinity Health supports this proposed change as it supports continuity of care for enrollees, which is critical to our goals of better health and better care.

Out-of-Network Cost Sharing for Services Provided at In-Network Locations

CMS has also proposed changes to address “surprise billing” issues enrollees may encounter by requiring that a provider network count enrollee cost sharing for an Essential Health Benefit (EHB) provided by an out-of-network provider in an in-network setting under certain circumstances toward the annual cost sharing limit for that enrollee. CMS also provides issuers the option to provide written notice to an enrollee at least 10 business days before the service is received to notify them that additional costs may be incurred if they use an out-of-network provider (even if the service is received in an in-network setting). Trinity Health supports this change as a short-term solution for consumers until a longer term solution can be identified. One of the long term solutions CMS should consider would be to structure consumer protections similarly to the requirements for those enrollees who receive out-of-network emergency care. In these cases, a plan must pay out-of-network providers the highest of 1) in-network rates; 2) UCR (usual, customary and reasonable) rates; or 3) Medicare rates for that service.

Patient Safety Standards for QHP Issuers

Trinity Health supports the proposed additions to existing patient safety standards. The changes would require QHP issuers contracting with hospitals with more than 50 beds to ensure that those hospitals use a patient safety evaluation system or other specified program or initiative to improve care coordination or reduce all cause preventable harm, or prevent readmissions. We believe these efforts are critical to supporting better health, better care, and lower costs. Trinity Health appreciates, and strongly supports, the proposed flexibility in achieving these standards by allowing QHP issuers to contract with hospitals that work not only with patient safety organizations (PSOs), but that are part of a Hospital Engagement Network, or participating in other initiatives that meet the core components of a hospital safety program. However, the timeline for compliance is unclear, and we suggest that hospitals be given one year from the date the rule is finalized to execute contracts with patient safety evaluation systems or programs. Our priority is to identify the optimal patient safety evaluation systems and programs for our facilities – and an appropriate transition time will support that effort.

Third Party Payment of QHP Premiums

Trinity Health supports CMS reconsidering expanding the list of entities from which issuers are required to accept third-party payments in order to include not-for-profit charitable organizations. We have previously advocated and continue to urge CMS to require QHPs offered through the exchanges to accept third-party premium and cost-sharing payments from hospitals, hospital-affiliated foundations, and other charitable organizations.
Trinity Health has long advocated that expanding access and coverage is an essential element of health care transformation. Public policies that limit the ability of hospitals or hospital-affiliated foundations and other charitable organizations to help individuals in need obtain access to health insurance coverage undermines a core objective of the Affordable Care Act (ACA) – making affordable insurance coverage available to the uninsured – and also adversely impacts the poor and the sick who need assistance the most. 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. CMS should consider studying the premium and cost-sharing non-payments that are occurring through the exchanges to better understand which populations are not making these payments, such as the medically poor or individuals with serious illness or injuries. While we understand CMS’ concern regarding risk pool impacts if insurers were encouraged to accept third-party payments from hospitals or hospital-affiliated foundations and other charitable organizations, we do not believe withholding this assistance is the appropriate policy response. Instead, CMS should focus on continually improving and strengthening risk adjustment models and fostering competitive exchanges to mitigate risk pool issues.

**State-Based Exchange on the Federal Platform**

Trinity Health supports the new proposed State-Based Exchange on the Federal Platform (SBE-FP) that would allow SBEs to use the federal eligibility and enrollment platform and information technology infrastructure. We believe it is important to give SBEs options in operating and leveraging enrollment and eligibility information systems to support long-term efficiency and sustainability.

**Hierarchy for Automatic Re-enrollment**

CMS has proposed a re-enrollment hierarchy for individuals who are eligible for cost-sharing reductions in a silver-level Qualified Health Plan (QHP) that will be discontinued. In this case, CMS proposes that the individual be automatically re-enrolled in a silver-level QHP offered by the same issuer that is most similar to the QHP the individual is enrolled in. First, Trinity Health urges that individuals be notified of the discontinuation of the QHP they are enrolled in so they have the opportunity to actively enroll in a plan that best meets their needs. We believe that enrollment processes must include robust education and transparency to ensure consumers have the opportunity to make informed decisions. CMS also solicited comments on how to determine product similarity. Assessing product similarity should be a holistic process that takes into account premiums, access to providers, prescription medicines, and other health services at affordable cost-sharing levels to ensure minimal disruption to an enrollee’s care needs.

**Annual Open Enrollment Period**

Trinity Health recommends that CMS consider moving the annual exchange open enrollment period so as not to overlap with Medicare Advantage open enrollment. For both payers and providers, the same personnel and resources are involved in marketing, product design, contracting, sales, and distribution. Significant resources go into both of these enrollment periods – as well as the filing deadlines leading up to them – and making them distinct periods reduces current administrative burdens and increases the potential to bring efficiencies at various levels including distribution channels, reviewers, payers, and others.
**Standardized Plan Options**

CMS proposed the creation of standardized plan options for issuers to offer in 2017. The option would include standardized cost-sharing structures, drug formularies, and provider tiers, among other factors. The options would not vary across states – and are designed to be similar to the most popular 2015 QHPs. While Trinity Health supports the concept of standardized plan options to promote consumer transparency and ease of plan comparison and shopping, we believe the offering should be optional for issuers as proposed.

**Permanent Risk Adjustment Program**

Trinity Health supports recalibration of the 2017 plan year risk adjustment model with claims data from 2012, 2013, and 2014. This will result in a better reflection of enrollee health risk and the costs of a given disease relative to average spending. We believe that continually improving and strengthening the risk adjustment model is especially critical starting in 2017 given that the transitional reinsurance and risk corridors programs will no longer be available to payers in the exchanges.

**Rate Increase Disclosure and Review**

Trinity Health supports requiring all issuers to submit the unified rate review template (URRT) for all single risk pool products in the individual and small group markets – whether or not they are proposing rate increases. We also support CMS posting proposed rates for all issuers, regardless of whether they are subject to rate review. We believe these provisions will promote transparency and overall affordability of exchange plans.

**Conclusion**

Trinity Health is appreciative of the opportunity to comment on the Notice of Benefit and Payment Parameters and thanks CMS for engaging with stakeholders throughout this process. We believe that the health insurance exchanges represent an ongoing opportunity to reach uninsured consumers and provide comprehensive, high-quality coverage to a range of individuals. We support a regulatory framework that promotes transparency, protects patients, and ensures that no groups are excluded from the opportunity to enroll in QHPs on the basis of health status, income, or ethnicity.

If you have any questions about our comments, please feel free to contact me at 734.343.0824 or wellstk@trinity-health.org.

Sincerely,

Tonya K. Wells  
Vice President, Public Policy & Federal Advocacy  
Trinity Health