December 1, 2016

Kevin Counihan
Center for Consumer Information and Insurance Oversight
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Ave. SW
Washington, DC 20201

Ref: Draft 2018 Letter to Issuers in the Federally Facilitated Marketplaces

Dear Mr. Counihan:

Thank you for the opportunity to submit comments on the above-mentioned draft letter to issuers in the federally facilitated and state-based health insurance marketplaces. While we support the Center for Consumer Information and Insurance Oversight’s (CCIOs) efforts to continually improve standards for the marketplaces, America’s Essential Hospitals continues to have concerns about qualified health plan (QHP) network adequacy.

America’s Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Filling a vital role in their communities, our nearly 275 member hospitals provide a disproportionate share of the nation’s uncompensated care and devote approximately half of their inpatient and outpatient care to Medicaid or uninsured patients. More than a third of patients at essential hospitals are racial or ethnic minorities who rely on the culturally and linguistically competent care that only essential hospitals can provide. Our members provide this care while operating on margins substantially lower than the rest of the hospital field—a zero percent aggregate operating margin compared with 8.3 percent for all hospitals nationwide.¹ Through their integrated health systems, members of America’s Essential Hospitals offer a full spectrum of primary through quaternary care, including trauma care, outpatient care in their ambulatory clinics, public health services, mental health services,

substance abuse services, and wraparound services critical to vulnerable patients.

Many of the patients treated by our member hospitals have gained coverage for the first time through the marketplaces, and many are likely to transition into and out of marketplace coverage over time. As patients’ coverage status changes, participation of essential community providers (ECPs) in QHP networks is vital for maintaining access to services and ensuring continuity of care. Because these low-income patients generally are not as healthy as those with private coverage and they typically receive less preventive care, they have come to rely on the extensive services our members provide.²

To ensure the continued integrity of QHP networks, CCIIO should consider the following comments when finalizing the above-mentioned proposed rule.

1) CCIIO should amend the ECP standard to require QHP issuers to offer contracts, in good faith, to every willing ECP hospital in each county of a plan’s service area.

CCIIO should require issuers to offer good-faith contracts to all ECPs and should develop specific requirements for including essential hospitals. It is particularly important to include these requirements to protect reasonable and timely access to vital health services for low-income and underserved patients.

Essential hospitals are cornerstones of coordinated care for the nation’s low-income and vulnerable populations. They are unique because of the extensive services they provide and the diverse populations they serve. Specifically, essential hospitals:

- demonstrate through practice a commitment to caring for vulnerable people, especially Medicaid patients and the uninsured;
- provide comprehensive, coordinated care to their communities;
- deliver specialized, high-acuity care—level I trauma care, for example—and often are the sole provider of such care in their community;
- advance public health and essential community services; and
- train the next generation of clinicians at levels greater than other hospitals.

If essential hospitals are excluded from QHP networks, patients will lose access to these vital health services. For the benefit of patients, we urge CCIIO to

further develop the requirements for including essential hospitals in QHP networks when they are located in QHP service areas.

The current standard still is not stringent enough to ensure all ECPs are included in provider networks. It also leaves room for QHPs to exclude the essential hospitals that provide low-income and medically underserved populations the full continuum of quality care. According to CCIIO’s letter, similar to previous years’ thresholds, QHP issuers must demonstrate at least 30 percent of ECPs in a plan’s service areas are included in the plan’s network. Also, in keeping with requirements in last year’s issuers letter, QHPs would have to offer contracts, in good faith, to all Indian Health Service providers and at least one ECP in each ECP category in each county of a plan’s service area. In most cases, only a handful of essential hospitals are included in the QHP networks offered in the hospital service area. The majority of essential hospitals have reported contracts with only a limited number of QHPs. Essential hospitals fulfill such a unique role in their communities that specific guidance on including these providers in QHP networks is warranted. To this end, CCIIO should require QHP issuers to offer contracts, in good faith, to all willing ECP hospital providers, especially essential hospitals, in each county of their service area, such that low-income and medically underserved patients have reasonable and timely access to vital health services.

2) CCIIO should monitor QHP contracts to ensure QHP issuers are offering ECP hospitals adequate payment rates that support the complex services they provide.

CCIIO should monitor contracts offered by QHP issuers to ensure payment rates offered to ECP hospitals are adequate to support the unique services, such as trauma, burn, neonatal, and other specialty services, these essential hospitals provide. One major challenge that essential hospitals face is that QHPs offer them payment rates that are significantly below the cost of providing care. CCIIO states that contracts extended to ECPs should be in good faith and offer terms that a willing, similarly situated, non-ECP provider would accept or has accepted. But essential hospitals offer extensive and costly vital services that many non-ECP hospitals do not offer. Thus, rates offered to non-ECP providers are not always sufficient to cover the increased costs essential hospitals incur providing these extensive and costly services. These hospitals already operate on tight margins and cannot afford to accept these terms.

Furthermore, even those essential hospitals that have been able to contract with the QHPs in their service areas are concerned about future inclusion, as the payment levels are not favorable now and might continue to decrease over time. Adequate payment levels are critical to ensuring ECP hospitals can provide access to care for low-income patient populations without continuing to face the
extraordinary, and unsustainable, levels of uncompensated care present under
the current system.

According to one study, QHPs nationwide use narrow hospital networks as a
cost-control lever. But because this practice excludes many ECPs, it ends up
limiting patients' access to crucial hospital services and the providers on which
they rely. If this continues, patients will have to choose whether to pay a higher
price to access their longstanding ECP provider or pay less to see someone with
whom they have no existing relationship or who might not provide the same vital
services. Our member hospitals worry about how this choice will affect patient
populations seeking their essential hospital services. Accessible, high-quality
care should not be a luxury for those who can pay; it should be considered part
and parcel of the coverage every American can affordably access. That is the
promise of the Affordable Care Act, but the trend toward narrow networks that
exclude ECPs undercuts that promise.

America's Essential Hospitals supports the clarification of good faith contracts
and encourages CIIIO to elaborate on how that affects QHP offers to ECPs and,
in particular, essential hospitals. To ensure vulnerable populations continue to
have sufficient and timely access to hospital services, QHP contracts must
adequately and fairly pay for these services, which might not be provided
elsewhere in the community. It would be inappropriate for a QHP to offer a
disproportionate share hospital that is part of an academic medical center the
same rates as a community hospital and claim it has offered a contract in good
faith. Therefore, CIIIO should review contracts QHP issuers offer to ECP
hospitals to ensure these providers are reimbursed at adequate rates,
enabling continued access to care for low-income and medically
underserved populations.

3) Network adequacy reviews should ensure patients have access to all
hospital services within their plan's network.

CIIIO or any agency conducting reviews for network adequacy should
evaluate QHPs, through the reasonable access review standard, to ensure
plan networks include hospitals that offer all of the essential services on
which low-income and medically underserved patients rely. CIIIO also
should further develop its standards to include specific criteria for
determining when a plan’s network is deemed adequate. Under the
reasonable access standard in its current form, CIIIO will review a provider
network during the certification process to ensure it is “sufficient in number and

---

3 Leonard Davis Institute of Health Economics and Robert Wood Johnson Foundation. The Skinny on
Narrow Networks in Health Insurance Marketplace Plans.
http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf421027. Accessed November
2016.
types of providers, including providers that specialize in mental health and substance abuse disorder services, to assure that all services will be accessible to enrollees without unreasonable delay,” as established in 45 C.F.R. § 156.230(a)(2). The Centers for Medicare & Medicaid Services (CMS) will assess provider networks using this standard to identify networks that fail to provide adequate access to services using these quantifiable network adequacy metrics:

- prospective time and distance standards; and
- prospective minimum provider-covered person ratios for “the specialties with the highest utilization rate for its state.”

In its letter, CCIIO maintains the process for demonstrating network adequacy that was established in previous rulemaking, whereby QHPs submit detailed provider data during certification that include all in-network providers and facilities for all plans. CMS will review this provider data according to a reasonable access standard that identifies whether patients will have access to all services without unreasonable delay. The agency will focus specifically on the inclusion of providers who historically have raised concerns about network adequacy, such as hospital systems. CMS also will use a justification process, which allows QHP issuers to detail how they meet the reasonable access standard, despite not meeting the time and distance standards.

When evaluating QHPs, CMS should use both quantitative and qualitative criteria to ensure these plans include providers that offer the full range of primary through quaternary care, including trauma care; public health, mental health, and substance abuse services; and wraparound services particularly important to vulnerable patients.

It is imperative to note that measuring the number of participating hospital providers in QHP networks does not discern whether beneficiaries have adequate access to all essential hospital services. Hospitals vary in the services they provide to their communities. A community hospital, for example, does not have the resources to provide complex services, whereas essential hospitals and academic medical centers provide complex, high-acuity care to their communities daily. Thus, each hospital cannot be quantified in the same way as, perhaps, each primary care physician in a network could be. Therefore, CCIIO and CMS should undertake a more qualitative review to ensure patients can access trauma care and other vital hospital services within their QHP networks.

During the review process, CMS should scrutinize tiered networks, which pay providers different rates for covered services depending on their tier placement. Reviews should ensure ECPs in tiered arrangements receive reimbursements sufficient to cover the cost of providing complex care. CMS also should determine a QHP’s network adequacy by evaluating only the providers in the
lowest cost-sharing tier. Furthermore, the agency should evaluate plan networks to ensure issuers do not arbitrarily place certain hospitals in higher cost-sharing tiers and that the same benefits are available to patients across QHP tiers. In many states, the tier placement of our member hospitals hinders patient access to all hospital services. Hospitals in preferred tiers have the lowest out-of-pocket costs for patients but do not necessarily provide a comprehensive suite of services. Patient costs rise when they seek care in hospitals placed in less favorable tiers. Many essential hospitals have been placed in less favorable tiers and offered a better tier only if they accept reimbursement rates at levels far below the cost of providing care to vulnerable patients. Typically, payments in these less-favorable tiers are based on rates community hospitals will accept. But community hospitals do not offer the same breadth of services as our member hospitals. As a result, many vulnerable patients face a no-win decision: lose access to their established providers and vital hospital services or pay more out of pocket, which many cannot afford.

Another important aspect of network adequacy is linguistic and cultural competency. Members of America’s Essential Hospitals have a long history of providing culturally sensitive care, including interpretation, transportation, and other social services to diverse, low-income populations. These services reach beyond the walls of the hospital to provide comprehensive care to vulnerable populations. Essential hospitals’ experience handling such complex medical and social conditions is invaluable to the health and productivity of entire communities.

Due to these well-established and trusted patient-provider relationships, many patients likely will continue to seek care from their current providers regardless of whether these providers are included in their marketplace plan networks. This tendency was demonstrated during coverage expansion in Massachusetts several years ago. One study demonstrated that patients continued to seek care from their established providers due to a preference for the types, affordability, and convenience of the offered services. Additionally, patients stressed the importance of the nonmedical services, such as translation services, their providers offer. The study also found that essential hospitals continue to be the predominant providers to high-risk patients after coverage expansion, further establishing their importance to the community.⁴

If patients cannot access the services essential hospitals provide within their plan networks, they will face additional out-of-pocket costs just to maintain these vital relationships. Others will have to disrupt their care continuum to find new providers. Maintaining standards that could exclude these ECPs from QHPs would only serve to hinder access to vital hospital services for these patient

populations. Merely counting the number of hospitals or other providers in a network plan does not account for the types of specialized services essential hospitals provide. As such, **CMS should conduct a qualitative review of QHPs during reasonable access reviews to ensure QHPs include ECP hospitals that are uniquely suited to offer highly complex services to a diverse set of patients. In doing so, patient access to the full range of essential hospital services within plan networks is protected.**

****

The association appreciates the opportunity to submit these comments and looks forward to additional opportunities to work with CCIIO on this vital issue. If you have questions, please contact Erin O’Malley, policy director, at 202-585-0127 or eomalley@essentialhospitals.org.