



AMERICA'S ESSENTIAL HOSPITALS

March 7, 2017

Patrick Conway, MD, MSc
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue SW
Washington, DC 20201

Ref: CMS-9929-P: Patient Protection and Affordable Care Act; Market Stabilization

Dear Dr. Conway:

America's Essential Hospitals appreciates the opportunity to submit comments on the above-captioned rule proposing changes aimed at stabilizing the health insurance marketplaces. While we support the Centers for Medicare & Medicaid Services' (CMS') efforts to 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 vulnerable. Filling a vital role in their communities, our nearly 300 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 our members' patients 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 ambulatory clinics, public health services, mental health services, substance abuse services, and wraparound services critical to vulnerable patients.

¹ Landry C, Ramiah K, Rangarao S, Roberson B. 2014 Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2014 Annual Member Characteristics Survey. America's Essential Hospitals. June 2016. <http://essentialdata.info>. Accessed February 2017.

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 typically receive less preventive care, they have come to rely on the extensive services our members provide.²

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

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

CMS proposes to rely on states to conduct network adequacy reviews, rather than the time-and-distance evaluation that was finalized in previous marketplace rulemaking. States with adequate minimum access standards and review processes will assume the responsibility of ensuring insurer compliance with network adequacy requirements. For states that do not have the authority or means to conduct sufficient network adequacy reviews, CMS proposes to rely on issuers' accreditation from an accrediting agency recognized by the Department of Health and Human Services (HHS). CMS and any state agency conducting reviews for network adequacy should evaluate QHP networks to ensure inclusion of hospitals that offer all of the essential services on which low-income and medically underserved patients rely. CMS should develop standards that incorporate specific criteria for states as they determine when a plan's network is deemed adequate. The evaluation of QHP networks should use both quantitative and qualitative criteria so that these plans include providers that offer the full range of primary through quaternary care.

It is imperative to note that simply 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, CMS should ensure that states, as they conduct network adequacy reviews, safeguard patient access to trauma care and other vital hospital services within their QHP networks.

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 the providers are in their marketplace plan networks. If patients cannot access the services essential hospitals provide within their plan networks, they will face additional out-of-

² The Henry J. Kaiser Family Foundation. Key Facts about the Uninsured Population. September 2016. <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>. Accessed February 2017.

pocket costs to maintain these vital relationships. Others will have to disrupt their care continuum to find new providers.

Allowing states to conduct network adequacy reviews, without CMS maintaining standards or providing oversight, could lead to exclusion of ECPs from QHPs. This would only serve to hinder access to vital hospital services for vulnerable patient populations. **As such, CMS should not shift network adequacy reviews to states without setting specific criteria that guarantee 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.**

2. CMS should amend the ECP standard to require QHP issuers offer contracts, in good faith, to every willing ECP hospital in each county of a plan's service area.

QHPs must include at least 30 percent of all available ECPs in its service area to meet network adequacy requirements. CMS proposes to decrease this percentage to 20 percent for 2018. CMS notes that this standard will lessen the burden on issuers while preserving access to care provided by ECPs. **However, CMS should require issuers to offer good-faith contracts to all ECP hospitals 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 at-risk communities.**

Essential hospitals are cornerstones of coordinated care for their communities and 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 communities;
- 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 CMS to further develop the requirements for including essential hospitals in QHP networks when they are located in QHP service areas.

Decreasing the ECP inclusion standard does not ensure all ECPs are 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. Essential hospitals fulfill such a unique role in their communities that specific guidance on including such providers in QHP networks is warranted. **To this end, CMS 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.

3. CMS should allow issuers to identify, through a write-in process, all ECPs in their provider networks.

In previous rulemaking for marketplaces in 2018, CMS finalized the use of a CMS-established list of ECPs that insurers could choose from to include in QHP networks. CMS proposes to allow insurers to indicate in writing which ECPs are in their networks. CMS notes that the agency is aware that not all qualified ECPs submitted a petition to be included on the list and has determined that the write-in process to identify all ECPs in a QHP network is still needed. **CMS was right in that determination and, as such, should finalize this proposed change, which will allow for the complete identification of all ECPs in QHP networks.**

America's Essential Hospitals appreciates CMS' consideration of these comments and welcomes the opportunity to work with the agency on this vital issue. If you have questions, please contact Director of Policy Erin O'Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO