



## AMERICA'S ESSENTIAL HOSPITALS

October 6, 2016

Mr. Andrew Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Ave. SW  
Washington, DC 20201

**Ref: CMS-9934-P: Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2018**

Dear Mr. Slavitt:

Thank you for the opportunity to submit comments on the above-mentioned proposed rule regarding the federally facilitated and state-based health insurance marketplaces. While we support CMS' 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.<sup>1</sup> Through their integrated health systems, members of America's Essential Hospitals offer a full spectrum of primary through quaternary care, including trauma care, outpatient

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<sup>1</sup> 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 August 2016.

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, essential community providers (ECP) participation 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.<sup>2</sup>

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

- 1) CMS should require QHP issuers to offer contracts, in good faith, to every willing ECP hospital in each county of a plan's service area.

To ensure adequate hospital participation in QHP networks, CMS should require issuers to offer good faith contracts to all ECPs in a plan's service area and should develop specific requirements for including essential hospitals. Such requirements would protect reasonable and timely access to vital health services for low-income and underserved patients.

Our member hospitals are in a unique position to provide essential services to the nation's low-income and vulnerable populations. 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 and communities will lose access to these vital health services. For this reason, we

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<sup>2</sup> The Henry J. Kaiser Family Foundation. *Key Facts about the Uninsured Population*. October 2015. <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>. Accessed September 16, 2016.

urge CMS to further develop the requirements for including essential hospitals in QHP networks when such hospitals are located in plan service areas.

The current standard is not stringent enough to ensure all types of ECPs are included in provider networks, leaving room for QHPs to exclude essential hospitals. Existing standards hold that QHP issuers demonstrate at least 30 percent of ECPs in a plan's service area are included in its network. In keeping with requirements outlined in previous letters to issuers in the federally facilitated marketplaces, QHPs also would have to offer contracts, in good faith, to all Indian Health providers and at least one ECP in each ECP category in each county of a plan's service area. In addition to Indian Health providers, CMS has defined the major ECP categories to include federally qualified health centers, Ryan White providers, family planning providers, hospitals, and other entities that serve predominately low-income, medically underserved individuals. Only a handful of essential hospitals currently are included in QHP networks. Essential hospitals fulfill such a unique role in their communities that specific guidance on including these hospital providers in QHP networks is warranted. **To this end, CMS should require QHP issuers to offer contracts, in good faith, to all willing ECP hospitals—especially essential hospitals—in each county of their service area, such that low-income and medically underserved patients have reasonable and continued access to vital health services.**

- 2) CMS should continue to ensure patients have access to all hospital services within their plan's network.

QHPs must be evaluated to ensure plan networks include hospitals that offer all of the essential services on which low-income and medically underserved patients rely. America's Essential Hospitals urges CMS to develop specific criteria for determining whether a plan's network is adequate. Under the reasonable access standard, provider networks are reviewed during the certification process to ensure they are "sufficient in number and types of providers, including providers that specialize in mental health and substance abuse disorder services, to assure that all services will be accessible without unreasonable delay," as established in 45 C.F.R. § 156.230(a)(2). Further, in the 2017 payment notice, the U.S. Department of Health and Human Services finalized a policy on providing information about QHP network breadth to consumers.<sup>3</sup>

Hospitals vary in the services they provide to their communities. Essential hospitals and academic medical centers provide complex, high-acuity care to their communities every day that other hospitals might not have the resources to

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<sup>3</sup> 81 Fed. Reg. 12203 (March 8, 2016).

offer. Thus, each hospital cannot be quantified in the same way as, perhaps, each primary care physician in a network could be. And, 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 CMS considers incorporating more specific indicators of network breadth, it is imperative to note that measuring the number of participating hospital providers in QHP networks does not discern whether plan beneficiaries have adequate access to all essential hospital services. **CMS should undertake a more qualitative review to ensure patients are able to access trauma care and other vital hospital services within their QHP networks and indicate such specificity for consumers on HealthCare.gov.**

CMS also 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 their cost of providing complex care. A QHP's network adequacy should be determined by evaluating only the providers in the lowest cost-sharing tier to ensure patient access to care. Further, **the agency should evaluate plan networks to ensure that 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 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 of our member hospitals have been placed in less-favorable tiers and are offered a better tier only if they accept reimbursement rates at levels far below their cost of providing care to vulnerable patients. Typically, payments in these less-favorable tiers are based on rates that are sufficient to cover the costs of hospitals that do not offer all of the comprehensive services that essential hospitals provide. As a result, many vulnerable patients face a no-win decision: lose vital access to their established providers at essential hospitals 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 deep experience and a long history of providing culturally sensitive care—including interpretation, transportation, and other social services—to diverse populations. These services reach beyond the walls of the hospital to provide comprehensive care where patients need it. Essential hospitals' experience handling such complex medical and social conditions is invaluable to the health and productivity of entire communities and should be evaluated as part of a QHP network.

If patients cannot access such services within their plan networks, they will face additional out-of-pocket costs to maintain vital relationships with their providers. Others will have to disrupt their care continuum to find new providers. Maintaining standards that could exclude these ECPs from QHPs would only hinder access to vital hospital services for these patient populations. To protect patients' access to care, **CMS should evaluate plan networks and specify to consumers which QHP networks best ensure patient access to the full spectrum of essential hospital services.**

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