November 27, 2017

Seema Verma, MPH
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-9930-P: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019

Dear Ms. Verma:

America’s Essential Hospitals appreciates the opportunity to comment 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 the marketplaces, America’s Essential Hospitals continues to have concerns about enhanced state flexibility in reviewing qualified health plan (QHP) network adequacy and the definition of essential health benefits (EHBs).

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 325 member hospitals provide a disproportionate share of the nation’s uncompensated care and devote about half of their inpatient and outpatient care to Medicaid or uninsured patients. Nearly half of member discharges in 2015 were for racial and ethnic minorities—patients who rely on the culturally and linguistically competent care only essential hospitals can provide. Our members provide this care while operating on margins substantially lower than other hospitals—a 3.2 percent aggregate operating margin compared with 7.4 percent for all hospitals nationwide.1 Through their integrated health systems, members of America’s Essential Hospitals offer a full spectrum of primary care through quaternary care, including trauma care, outpatient care in ambulatory clinics, public health services, mental health services, substance abuse services, and wraparound services vital to vulnerable patients.

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Many of the patients our members treat 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. Low-income patients, including those who rely on essential hospitals, generally are not as healthy as those with private coverage, and they typically receive less preventive care. These patients have come to depend on the extensive services only our members provide. State definitions of EHBs must be comprehensive so patients have coverage to meet their health care needs and access to essential providers.

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

1. **CMS should ensure that state definitions of EHBs include all necessary services to covered individuals, including primary and specialty care; services across the care continuum; critical care services, such as trauma and intensive-care services; and key enabling services, such as translation and social services.**

CMS proposes to give states additional flexibility in how they define EHBs for 2019 and beyond. The agency’s proposal would grant states more flexibility in regulating their respective markets and allow modifications to EHBs that increase affordability of marketplace plans. However, America’s Essential Hospitals is concerned this expanded flexibility, if lacking certain guardrails, could lead states to choose affordability over comprehensive coverage, leaving countless people with too little coverage to meet their health care needs and driving uncompensated care higher.

The benefits covered by EHB benchmark plans include many services essential to low-income patients, like hospitalization and prescription drugs, but the plans might not include all of the services that are needed to ensure high-quality care for this population. The reality is that some necessary services aren’t included in the 10 categories of essential health benefits. Patients will be responsible for significant amounts of their cost of care, leading to financial challenges for low-income patients. Essential hospitals that provide care to vulnerable, low-income patients will face uncompensated costs associated with uncovered services and unpaid cost-sharing for covered services. To reduce these uncompensated and uncovered costs, EHBs must include a minimum range of services, such as coordination programs, care management services, and language services that are available and affordable.

To ensure patients have access to comprehensive, affordable coverage for all their health needs, CMS must ensure state definitions of EHBs guarantee comprehensive coverage of necessary health care services.

2. **Network adequacy reviews should ensure patients have access to all hospital services within their plan’s network.**

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CMS proposes to further expand the state role by relying on state review of plans in states with federally facilitated marketplaces. 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 continue to rely on issuers’ accreditation from an accrediting agency recognized by the U.S. Department of Health and Human Services (HHS). We urge CMS and any state agency conducting reviews for network adequacy to evaluate QHP networks to ensure inclusion of hospitals that offer all 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 specialized hospital services within their QHP networks.

Many patients of essential hospitals have well-established and long-standing patient-provider relationships, and these 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-pocket costs to maintain these vital relationships. Others will have to disrupt their care continuum to find new providers.

Relying solely on 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.

3. CMS 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.

Previous rulemaking required a QHP to include at least 20 percent of all available ECPs in its service area to meet network adequacy requirements. CMS proposes to maintain this percentage in 2019. CMS notes 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.

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 in QHP service areas.

The 20 percent ECP inclusion standard does not 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. Essential hospitals fill 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.

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

CMS proposes to continue allowing insurers to use the previously finalized ECP write-in process to identify ECPs that are not included on the HHS list of available ECPs. CMS previously noted that it is aware not all qualified ECPs submitted a petition to be included on the list, and the agency 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, America’s Essential Hospitals supports CMS maintaining the write-in process, which allows for the complete identification of all ECPs in QHP networks.

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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