## AMERICA'S ESSENTIAL hospitals

December 11, 2017
Randy Pate, MPH
Deputy Administrator \& Director
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 2019 Letter to Issuers in the Federally Facilitated Marketplaces

Dear Mr. Pate:
Thank you for the opportunity to comment 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 (CCIIO's) 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 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 on average 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.

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. As

[^0]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, such as those who rely on essential hospitals, generally are not as healthy as those with private coverage and typically receive less preventive care. ${ }^{2}$ These patients have come to depend on the extensive services only essential hospitals provide.

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

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

As noted in the draft letter, the Centers for Medicare \& Medicaid Services (CMS) proposed in the 2019 Notice of Benefit and Payment Parameters rule to further expand the state role by relying on state review of plans in states with federally facilitated marketplaces. ${ }^{3}$ 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 CCIIO, 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. Standards must be developed that incorporate specific criteria for states as they determine whether to deem a plan's network as 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 care 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, as they conduct network adequacy reviews, states must 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 patientprovider relationships, and these patients likely will continue to seek care from their current providers regardless of whether the providers participate 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 crucial relationships. Others will have to disrupt their care continuum to find new providers.

[^1]Relying solely on states to conduct network adequacy reviews, without 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, network adequacy reviews must not be shifted 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. 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 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 important 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 in QHP service areas.

The current 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 them in QHP networks is warranted. To this end, CCIIO should require QHP issuers to offer contracts, in good faith, to all willing ECP hospital providersespecially essential hospitals-in each county of their service area, such that lowincome and medically underserved patients have reasonable and timely access to vital health services.
3. CCIIO, with CMS, should strengthen its mechanisms to inform providers about the ECP petition process and allow issuers to identify, through a write-in process, all ECPs in their provider networks.

In the draft letter, CCIIO notes that 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.

However, we recommend that CCIIO, working with CMS, continue to strengthen its mechanisms to inform providers about the deadline to submit ECP petitions before the annual ECP list is finalized. It is crucial that there is a full and accurate accounting of available ECPs in a service area, given their role as key providers of health care for underserved and vulnerable populations. We look forward to continuing to work with the agencies in the coming months to improve the database and identify additional communication channels for providers.

America's Essential Hospitals appreciates CCIIO's 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


[^0]:    ${ }^{1}$ Roberson B, Ramiah K. Essential Data: Our Hospitals, Our Patients-Results of America's Essential Hospitals 2015 Annual Member Characteristics Survey. America's Essential Hospitals. June 2017. www.essentialdata.info/. Accessed November 9, 2017.

[^1]:    ${ }^{2}$ The Henry J. Kaiser Family Foundation. Key Facts about the Uninsured Population. September 19, 2017. https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/. Accessed November 9, 2017.
    ${ }^{3} 82$ Fed. Reg. 51052 (November 2, 2017).

