



# AMERICA'S ESSENTIAL HOSPITALS

January 27, 2022

Chiquita Brooks-LaSure  
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

## **CMS-9911-P: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023**

Dear Administrator Brooks-LaSure:

America's Essential Hospitals appreciates the opportunity to submit comments on the above-captioned interim final rule related to qualified health plans (QHPs). While we strongly support restoring and expanding the nondiscrimination protections, we continue to have concerns about QHP network adequacy and inclusion of essential hospitals in QHPs.

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all. Filling a vital role in their communities, our more than 300 member hospitals provide a disproportionate share of the nation's uncompensated care, and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. Our members provide state-of-the-art, patient-centered care while operating on margins a third that of other hospitals—2.9 percent on average compared with 8.8 percent for all hospitals nationwide.<sup>1</sup>

Essential hospitals are committed to serving all people, regardless of income or insurance status. Their patients face sociodemographic challenges to accessing health care, including poverty, homelessness, language barriers, and low health literacy. Ten million people in communities served by essential hospitals have limited access to healthy food, and nearly 24 million live below the poverty line.<sup>2</sup> Essential hospitals are uniquely situated to target these social determinants of health (SDOH) and are committed to serving these patients. These circumstances, however, compound essential hospitals' challenges and strain their resources, requiring flexibility to ensure they are not unfairly disadvantaged for serving marginalized patients and can continue to provide vital services in their communities.

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<sup>1</sup> Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2019 Annual Member Characteristics Survey*. America's Essential Hospitals. May 2021. <https://essentialdata.info>. Accessed January 12, 2022.

<sup>2</sup> Ibid.

We are pleased to see federal network adequacy reviews for QHPs will resume in plan year 2023. Regardless of which entity runs an insurance marketplace, all QHPs should be subject to the same network adequacy assessments to provide equitable access to health services for all QHP beneficiaries. We are encouraged CMS continues to take steps to ensure QHPs provide comprehensive coverage for primary and specialty care services. However, we remain concerned that essential community provider (ECP) threshold requirements and network adequacy standards do not ensure more essential hospitals are included in QHP networks, thus maintaining access to patients' same providers as their insurance coverage changes

**1. CMS must ensure equitable access to QHP beneficiaries' preferred health care provider through ECP threshold requirements and network adequacy standards.**

Many patients treated by essential hospitals have gained coverage through the Affordable Care Act marketplaces, and many are likely to transition into and out of marketplace coverage over time. Depending on a patient's employment status and varying amount of work hours, their qualification for employer-based, marketplace, or public insurance might change frequently. As patients' health insurance changes, participation of essential hospitals in QHP networks is vital for maintaining access to services and ensuring continuity of care. As uninsured patients or Medicaid beneficiaries gain or switch to marketplace coverage, or vice versa, they should retain access to their same providers and needed services.

a. CMS must improve ECP threshold standards to ensure beneficiaries maintain access to their established providers as their eligibility for health coverage changes.

While we appreciate the proposed increase to require QHPs to include 35 percent of available ECPs in-network, it does not guarantee inclusion of essential hospitals. The current standard only requires QHPs to contract with one provider per category, meaning only one ECP hospital is required to be in-network. Essential hospitals provide high-acuity care, such as level I trauma, burn, and neonatal care. In some cases, they are the only hospital in their community or region to provide these services. Further, they provide wraparound services (case management, transportation, nutrition support, legal services, language access, and patient navigation, among others) to meet the needs of their patients facing socioeconomic barriers—the same patients whose eligibility for marketplace coverage is more likely to change over time.

Patients with low incomes should be able to maintain access to their same providers and needed wraparound services as their insurance eligibility changes, especially for those with incomes at or near Medicaid eligibility levels. Finding new providers because of a change in insurance is disruptive to care, particularly for communities served by essential hospitals. Maintaining the same provider across health coverage leads to better health outcomes. Continuity of care is associated with decreased emergency department use and hospitalizations, lower costs, and higher patient satisfaction, as well as lower mortality rates.<sup>3,4</sup> **To ensure equitable access to beneficiaries' provider of choice, CMS must employ ECP threshold standards that include all willing ECPs as in-network for QHPs.**

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<sup>3</sup> Goodwin J. Continuity of care matters in all health care settings. *JAMA Network Open*. 2021;4(3):e213842. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2777855>. Accessed January 13, 2022.

<sup>4</sup> Gray D, Sidaway-Lee K, White E, Thorne A, Evans P. Continuity of care with doctors- a matters of life and death? A systematic review of continuity of care and mortality. *BMJ Open*. 2018;8:e021161. <https://bmjopen.bmj.com/content/8/6/e021161#main-content>. Accessed January 12, 2022.

- b. CMS must include access to all levels of emergency care in the QHP network adequacy time and distance standard for emergency medicine.

We are pleased emergency medicine will be added to the provider specialty list for network adequacy time and distance standards. All QHPs beneficiaries need equitable access to this vital service. However, all emergency medicine is not the same. In 2010, almost 30 million Americans lacked access to a level I or II trauma center; areas with higher rates of uninsured and Medicaid- or Medicare-eligible patients were less likely to have access. The same was true for areas with higher proportions of people of color and foreign-born persons.<sup>5</sup>

Unforeseen illnesses and injuries require varying levels of emergency care available with specific emergency physicians at various trauma centers, though not every emergency department is designated a level I or II trauma center. To ensure QHP beneficiaries have access to the care they need, **we urge CMS to include equitable access to the various levels of trauma centers in the time and distance standards for emergency medicine.**

- c. CMS should not use appointment wait times to measure network adequacy for QHPs.

We are concerned about the use of appointment wait times as a measure of network adequacy for primary care, behavioral health, and non-urgent specialty care in QHPs. On the surface, appointment wait times seem a simple measure of network adequacy: the longer a patient has to wait to see a provider, the more likely the QHP needs more in-network providers. However, several factors can contribute to longer wait times even if a plan has adequate access to a given provider.

As safety net providers, essential hospitals serve a disproportionate number of uninsured patients and Medicaid beneficiaries, as well as provide specialty services not available at other hospitals in the community. Both instances create increased demand for services as more patients seek care from fewer providers, leading to longer appointment wait times. Essential hospitals provide highly specialized services to complex patients—few health care providers can offer such highly complex care. Therefore, there often is a longer waiting period before a patient can see that specialized provider, as compared to primary care. While an appointment wait time measure might encourage QHPs to increase the number of in-network providers, it does not account for the unique circumstances of essential hospitals.

Further, an appointment wait time measure does not account for issues related to care-seeking behavior or forced cancellations, as illustrated by the COVID-19 pandemic. By June 30, 2020, CDC estimated 41 percent of U.S. adults had delayed or avoided medical care because of concerns about COVID-19.<sup>6</sup> Not only does this create temporary shorter wait times, but potentially increases appointment wait times once patients seek the care they postponed. In addition, hospitals have delayed elective surgeries throughout the pandemic due to surges in

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<sup>5</sup> Carr B, Bowman A, Wolff C, et al. Disparities in access to trauma care in the United States: A population-based analysis. *Injury*. 2017;48(2):332–338. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5292279/>. Accessed January 12, 2022.

<sup>6</sup> Czeisler M, Marynak K, Clarke K, et al. Delay or Avoidance of Medical Care Because of COVID-19-Related Concerns—United States, June 2020. *Morbidity and Mortality Weekly Report*. 2020;69:1250–1257. <https://www.cdc.gov/mmwr/volumes/69/wr/mm6936a4.htm>. Accessed January 13, 2022.

COVID-19 cases; these delays also increase appointment wait times, inaccurately measuring network adequacy.<sup>7</sup>

Finally, an appointment wait time measure does not account for workforce shortages. The pandemic has caused critical workforce shortages in 20 percent of U.S. hospitals from staff burnout and staff becoming sick and having to isolate.<sup>8</sup> Beyond the current pandemic, the United States is expected to experience physician and nurse shortages within the next decade unless funding and training issues are mitigated.<sup>9,10</sup> The behavioral health workforce already was experiencing shortages before the pandemic. A 2018 study by the National Council for Mental Wellness reported 38 percent of Americans had to wait more than one week for mental health treatments and 46 percent had to drive more than an hour roundtrip to seek treatment.<sup>11</sup> However, the COVID-19 pandemic has made the situation much worse. The average share of adults reporting symptoms of anxiety or depression has significantly increased and one-third of Americans live in areas lacking mental health professionals, thus increasing demand on an already strained workforce.<sup>12,13</sup> In some places, a QHP could contract with all available behavioral health providers and still have extremely long appointment wait times. Further, workforce shortages at essential hospitals are exacerbated as they provide services to uninsured patients and Medicaid beneficiaries and compete for staff with more financially stable, for-profit systems.

Due to multiple factors outside the control of QHPs and providers, **CMS should not use appointment wait times to measure network adequacy.**

## **2. CMS should finalize proposed changes to nondiscrimination policies.**

America's Essential Hospitals strongly supports the nondiscrimination policies in the proposed rule as they promote equitable access to health care among marginalized communities.

### **a. CMS should prohibit discrimination based on sexual orientation and gender identity.**

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<sup>7</sup> Aboulenein A. Overwhelmed by Omicron surge, U.S. hospitals delay surgeries. *Reuters*. January 7, 2022. <https://www.reuters.com/world/us/overwhelmed-by-omicron-surge-us-hospitals-delay-surgeries-2022-01-07/>. Accessed January 11, 2022.

<sup>8</sup> Levin J. U.S. Hospital Staff Shortages Hit Most in a Year on Covid Surge. *Bloomberg*. January 5, 2022. <https://www.bloomberg.com/news/articles/2022-01-05/one-in-five-u-s-hospitals-face-staffing-shortages-most-in-year>. Accessed January 13, 2022.

<sup>9</sup> Association of American Medical Colleges. New AAMC Report Confirms Growing Physician Shortage. June 26, 2020. <https://www.aamc.org/news-insights/press-releases/new-aamc-report-confirms-growing-physician-shortage>. Accessed January 10, 2022.

<sup>10</sup> *Workforce*. American Nurses Association. <https://www.nursingworld.org/practice-policy/workforce/>. Accessed January 10, 2022.

<sup>11</sup> Wood P, Burwell J, Rawlett K. New study reveals lack of access as root cause for mental health crisis in America. National Council for Mental Wellbeing. October 10, 2018. <https://www.thenationalcouncil.org/press-releases/new-study-reveals-lack-of-access-as-root-cause-for-mental-health-crisis-in-america/>. Accessed January 11, 2022.

<sup>12</sup> Panchal N, Kamal R, Cox C, Garfield R. The implications of COVID-19 for mental health and substance use. Kaiser Family Foundation. February 10, 2021. <https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>. Accessed January 11, 2022.

<sup>13</sup> USA Facts. Over one-third of Americans live in areas lacking mental health professionals. July 14, 2021. <https://usafacts.org/articles/over-one-third-of-americans-live-in-areas-lacking-mental-health-professionals/>. Accessed January 13, 2022.

We strongly support amending the nondiscrimination protections in 45 CFR 147.104(e) to once again explicitly prohibit discrimination based on sexual orientation and gender identity in QHPs. Expanding access to health coverage is an important tool for improving access to care for the LGBTQ community, which is more likely to delay care, less likely to have a usual source of care, and more likely to experience health outcome disparities than individuals who do not identify as LGBTQ.<sup>14</sup>

Essential hospitals take pride in providing high-quality care to all, including members of the LGBTQ community. In 2020, more than 90 essential hospitals took part in the Human Rights Campaign's Healthcare Equality Index (HEI), an annual report measuring policies and practices designed to support LGBTQ patients, including in health care settings.<sup>15</sup> The voluntary survey evaluates facilities' policies and practices and identifies gaps where there is room for improvements. Sixty-four essential hospitals were designated as LGBTQ Healthcare Equality Leaders, earning the highest possible score on the HEI and demonstrating their dedication to equity, while an additional 24 were designated as top performers. Essential hospitals have long valued and developed specialized services for LGBTQ patients. For example, one essential hospital in Ohio runs a clinic to respond to the unique needs of transgender youth, who face an extremely high risk of attempting self-harm.<sup>16</sup>

Federal policies must reinforce equity of care for all patients, regardless of socioeconomic and sociodemographic characteristics or insurance coverage. While essential hospitals take pride in providing care to all patients, regardless of their sexual orientation or gender identity, not all issuers or providers are compelled to do so. As noted above, not all essential hospitals are in QHPs, making it even more critical the federal government enforce nondiscrimination policies.

**CMS must restore nondiscrimination policies based on sexual orientation and gender identity in QHPs to ensure equitable access to health care for LGBTQ patients.**

- b. CMS should finalize essential health benefit nondiscrimination policies to ensure health plan designs are based on clinical evidence and provide equitable access to medically necessary services.

The association strongly encourages all benefit designs, benefit limitations, and plan coverage requirements be based on clinical evidence. Designing QHPs based on evidence-based guidelines, peer-review medical journals, and practice guidelines and recommendations from reputable governing bodies places medical decision-making back in the hands of providers and patients. Along with other nondiscrimination protections, providers and patients can choose the intervention that best suits their medical needs and goals.

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<sup>14</sup> Bosworth A, Turrini G, Pyda S, et al. Health insurance coverage and access to care for LGBTQ+ individuals. Department of Health and Human Services Assistant Secretary for Planning and Evaluation. June 2021. <https://aspe.hhs.gov/sites/default/files/2021-07/lgbt-health-ib.pdf>. Accessed January 12, 2022.

<sup>15</sup> Human Rights Campaign. Healthcare Equality Index 2020. 2020. [https://reports.hrc.org/healthcare-equality-index-2020?\\_ga=2.125079690.1692854610.1642530581-1608384250.1641585455](https://reports.hrc.org/healthcare-equality-index-2020?_ga=2.125079690.1692854610.1642530581-1608384250.1641585455). Accessed January 18, 2022.

<sup>16</sup> Toomey R, Syversten A, Shramko M. Transgender Adolescent Suicide Behavior. *Pediatrics*. 142:4. October 2018. <https://pediatrics.aappublications.org/content/142/4/e20174218>. Accessed January 13, 2022.

For patients of essential hospitals, if an item or service is medically recommended but not covered by their health coverage, they likely will forgo it or the hospital will accrue additional uncompensated care costs. For example, as discussed in the proposed rule, if hormone therapy is a covered essential health benefit but is denied to a patient based on their gender identity, even though it is medically necessary, the denial is discriminatory, and the patient will likely go without this gender-affirming care. Also discussed in the rule is the limitation on hearing aid coverage based on age. A person can experience hearing loss at any age, though some states include age limits in their benefit mandates. Hearing aids can be very expensive; if hearing aids are not covered by insurance, essential hospital patients likely will go without or the hospital will spend staff time and financial resources to provide the device or find an organization that will provide hearing aids at a discount. The proposed nondiscrimination policy will allow beneficiaries to receive the evidence-based care they need and providers to be reimbursed for the services they provide.

**CMS must finalize the essential health benefit nondiscrimination policy to ensure these benefits are based on clinical evidence and provide equitable access to medically necessary services.**

### **3. CMS should standardize the collection of Z codes for QHPs.**

Since 2015, providers have been able to use Z codes—a subset of ICD-10 codes—to capture SDOH information for beneficiaries. By encouraging collection of these data in a standardized manner, CMS can help ensure essential hospitals have the resources necessary to address the adverse impact social barriers have on health. Data is a key driver to inform providers about patient needs while engaging patients in their own care. However, there are challenges in the collection of SDOH data, including the sensitive nature of these conversations and a lack of alignment across screening tools. There also is the need to link data from medical and nonmedical sources (i.e., community services). These challenges should be addressed as part of a larger strategy to improve the use of Z codes.

When equipped with proper data, essential hospitals can innovate and collaborate with community partners to mitigate health disparities, improve outcomes, and reduce health care costs. For example, essential hospitals in Pennsylvania teamed up with schools and community organizations to form the North Philadelphia Health Enterprise Zone (HEZ). The initiative, launched in 2016, focuses on four key factors: health, community, education, and technology. Hospitals in the region struggled to share data across different electronic health record platforms. Hospitals supporting the HEZ now participate in the regional health information exchange, HealthShare Exchange, which allows real-time information sharing among care providers, reducing unnecessary or repeat procedures and driving down hospital costs. In fact, Pennsylvania recently made a financial investment in this collaborative to support HEZ efforts on employment and housing protections—activities that can help mitigate barriers to care and reduce disparities.<sup>17</sup>

**We urge CMS to support existing best practices in Z code data collection as a critical step in eliminating health disparities for QHP beneficiaries.**

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<sup>17</sup> George J. State invests \$4 million in North Philadelphia's Health Enterprise Zone. *Philadelphia Business Journal*. October 18, 2019. <https://www.bizjournals.com/philadelphia/news/2019/10/18/state-invests-4-million-in-north-philadelphia-s.html>. Accessed January 13, 2022.

**4. CMS should prorate premiums and advanced premium tax credits (APTCs) for cases in which enrollees are in marketplace plans for less than one month.**

America's Essential Hospitals supports ensuring all exchanges prorate premiums and APTCs when beneficiaries are enrolled in QHPs for less than a month. Not only would this help prevent APTC overpayment and subject beneficiaries to additional income tax liability, it also would encourage beneficiaries to enroll in a QHP as soon as they lose coverage from another source. As mentioned above, many patients treated by our member hospitals acquire coverage through the marketplaces and are likely to transition into and out of marketplace coverage over time, often needing to re-enroll in coverage mid-month. **We urge CMS to prorate premiums and APTCs as necessary to help beneficiaries maintain health coverage.**

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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, senior director of policy, at 202-585-0127 or [eomalley@essentialhospitals.org](mailto:eomalley@essentialhospitals.org).

Sincerely,

Bruce Siegel, MD, MPH  
President and CEO