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HOSPITALS

November 25, 2013

Marilyn Tavenner
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–2380–P
P.O. Box 8016
Baltimore, MD 21244–8016

Ref: CMS–2380–P, Proposed Rule Regarding Basic Health Programs

Dear Ms. Tavenner,

America's Essential Hospitals appreciates the opportunity to submit this response to the above-mentioned proposed rule. We thank the Centers for Medicare & Medicaid Services (CMS) for working to expand access to health care coverage for low-income individuals through the Basic Health Program (BHP). Proposals to make BHP an entitlement and to prohibit caps on enrollment are positive steps toward this goal.

We also support the proposal to allow health care provider groups to create standard health plans as part of the BHP. Members of America's Essential Hospitals have experience forming Medicaid managed care plans and other innovative programs to manage health care services delivered to uninsured patients, and they will bring this experience to the BHP. In fact, by forming their own provider networks under the BHP, our members and other essential providers can ensure access to their specialized services for low-income patients.

However, we are concerned about patients who do not have access to this type of provider network. We question whether the proposed rule will adequately ensure these low-income patients are able to obtain affordable coverage and access to appropriate care under a BHP.

America's Essential Hospitals represents more than 200 essential hospitals and health systems across the country. Filling a safety net role in their communities, our members predominately serve the uninsured and patients covered by public programs. Specifically, our members provide a disproportionate share of the

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nation's uncompensated care and devote more than half of their inpatient and outpatient care to uninsured or Medicaid patients. Many of these patients, at some point, are likely to seek coverage through the new and expanded programs established under the Affordable Care Act (ACA), including BHPs.

Americans must have continuous access to affordable care for the ACA's coverage expansion to succeed. BHPs could be an important tool for reaching that goal provided two key factors are taken into account. First, in states adopting a BHP, the program parameters must fit the needs of the targeted population. Second, the provider networks available to newly insured individuals under a BHP must be robust enough to ensure access to necessary services and continuity of care.

In response to the proposed rule, the comments below describe issues for CMS' consideration that are particular to essential hospitals.

1. CMS should ensure BHPs allow access to essential providers.

The ACA states that as part of the competitive bidding process for negotiating premiums, cost-sharing, and benefits, states must consider "local availability of, and access to, health care providers." However, **America's Essential Hospitals is concerned that CMS' proposal to use temporary safe harbor requirements to certify BHP provider networks does not guarantee essential providers will be included in the BHP networks, thus risking access for vulnerable patients.**

The preamble to the proposed rule states that CMS will issue future guidance on contract requirements for state BHP certification by the U.S. Department of Health and Human Services (HHS). Until that guidance is published, HHS will certify BHPs using a safe harbor approach involving provider network adequacy and other contract requirements applicable to either health insurance marketplace qualified health plans (QHPs) or Medicaid managed care.

Lawmakers did consider the importance of including essential providers in QHPs when drafting marketplace requirements in the ACA. In fact, the ACA obliges QHPs to contract with essential community providers (ECPs), defined for hospitals as participants in the 340B Drug Pricing Program. However, the resulting regulations have so far proven inadequate. In the April 5, 2013, letter to issuers on federally facilitated and state partnership marketplaces, CMS established the safe harbor for evaluating ECP network adequacy in QHPs on the federally facilitated marketplaces.

To meet the safe harbor for ECP inclusion, plans must achieve the following:

- demonstrate at least 20 percent of available ECPs in the plan's service area participate in the provider network
- offer contracts to all available Indian health providers

- offer contracts to at least one ECP in each ECP category in each county in the service area

Plans that provide a majority of covered professional services through employed physicians or a single contracted medical group are exempt from the ECP requirement if they can demonstrate that they meet an alternate standard ensuring reasonable and timely access for low income underserved individuals. We support this important exception for Qualified Health Plans and urge that it be retained in the BHP plans, and in particular those sponsored by for networks of healthcare providers pursuant to proposed 42 CFR §600.415(a)(3).

Members of America's Essential Hospitals have already reported that issuers in some marketplaces have excluded all or a portion of the member hospital system. Applying these same practices to the BHP will be detrimental to ensuring low-income individuals with BHP coverage actually have access to needed services.

Essential hospitals are well suited to meet the demands of BHP enrollees, as they have deep experience and a long history of providing culturally sensitive care to diverse, low-income populations. This experience translates into specialized services that patients prefer, such as translation and other social services. Patients also report preferring to go to essential providers for their care because they are convenient and affordable.[1]

Essential hospitals also are a critical component of the Medicaid system, as a large number of Medicaid and uninsured patients currently rely on essential hospitals for their care. Including these providers in BHPs and QHPs allows patients to continue with their familiar provider, preventing disruption to treatment regimens, medications, and health care provider relationships. While "continuity of care" can be a vague and overarching term, studies show that "interpersonal continuity" – continued access to the same provider – is associated with better health outcomes. In particular, interpersonal continuity is correlated with improved delivery of preventative services and lower rates of hospitalization.[2] Thus, ensuring that ECPs, including essential hospitals, are part of all Basic Health Plan provider networks will be critical to ensuring continuity of care particularly for those individuals who are likely to bounce between Medicaid, the Basic Health Plan and the marketplaces.

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[1]Ku L, Jones E, Shin P, Byrne F, Long SK. Safety-Net Providers After Health Care Reform: Lessons From Massachusetts. *Archives of Internal Medicine.* 2011;171(15):1379-1384. doi:10.1001/archinternmed.2011.317.

[2]Saultz JW, Lochner J. Interpersonal continuity of care and care outcomes: a critical review. *Annals of Family Medicine.* 2005:3(2):159-166. doi: 10.1370/afm.285.

Given the importance of essential providers to health care access for low-income populations, the use of QHP rules (until further guidance is issued) for certifying provider network adequacy in BHPs is of concern. CMS should work to ensure essential hospitals gain entry to BHP networks to secure crucial access for vulnerable populations.

2. CMS should require continuous enrollment for BHPs, as opposed to the marketplace open enrollment model.

In the proposed rule, states operating a BHP can choose between the enrollment policies used in the health insurance marketplaces or the continuous enrollment model used by Medicaid. Continuous enrollment allows individuals to sign up for coverage at any point during the year, instead of only during a set time frame. Requiring continuous enrollment for BHPs would provide a safety net for individuals who do not sign up for insurance coverage during the open enrollment period. Under an open enrollment model, if these individuals do not qualify for special enrollment with a significant life event, they can be precluded from obtaining affordable health insurance for months.

Particularly in the first years of the coverage expansion, reaching individuals unaware of their eligibility will take time. Recent surveys from the Commonwealth Fund and the Kaiser Family Foundation show that uninsured individuals are less likely to know about the individual mandate, the marketplaces, and the availability of financial assistance. In September, 74 percent of uninsured respondents did not know the marketplaces were opening October 1[3]; 67 percent did not know financial assistance to purchase insurance is available under the ACA. And awareness was significantly lower for those with incomes below 250 percent of the federal poverty level, compared to those with higher incomes.[4] Given the eligible population for a BHP is low-income and more likely to be uninsured, the program may face similar outreach barriers during its roll out. Members of America's Essential Hospitals assisting with enrollment will be better able to serve their patient populations if eligible individuals can be continuously enrolled in their state's BHP. **To support the program's goal of improving access to affordable care, CMS should require BHPs to use the Medicaid continuous enrollment model.**

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[3]Kaiser Family Foundation. Kaiser health tracking poll: September 2013. http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-september-2013/. Published September 28, 2013. Accessed October 15, 2013.

[4]Collins SR, Rasmussen PW, Doty MM, Garber T. What Americans think of the new insurance marketplaces and Medicaid expansion. The Commonwealth Fund. http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2013/Sep/1708_Collins_hlt_ins_marketplace_survey_2013_rb_FINAL.pdf. Accessed September 2013.

3. BHP reimbursements must be adequate to recognize and support the commitment of essential hospitals to serve all patients, including the most vulnerable.

BHP reimbursement must be adequate to recognize the commitment of essential hospitals to serve all patients, especially the most vulnerable, as well as the need for such providers to maintain complex, vital services such as trauma and burn units that serve entire regions. These services are a costly, yet critical, resource, and essential hospitals should be adequately and fairly paid to help support operations that may not burden other similarly situated providers (even though those providers may nonetheless have negotiated much higher reimbursement rates). Allowing payment rates to fall below this basic standard could place undue pressure on essential hospitals and their operations. A benchmark for BHP reimbursement rates could be the highest negotiated rates for any similarly situated providers (i.e., similar types of providers or those with similar services) or rates made available through QHPs offered in the marketplace exchanges.

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America's Essential Hospitals appreciates the opportunity to submit these comments and looks forward to providing more feedback on other aspects of coverage expansion. If you have any questions, please contact Xiaoyi Huang at (202) 585-0127.

Sincerely,

Bruce Siegel, MD, MPH
President and Chief Executive Officer