AMERICA'S
ESSENTIAL
HOSPITALS

February 25, 2014

Gary Cohen
The Center for Consumer Information and Insurance Oversight
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Ref: Draft 2015 Letter to Issuers in the Federally Facilitated Marketplaces

Dear Mr. Cohen,

America's Essential Hospitals appreciates the opportunity to submit these comments in response to the above mentioned letter, which offers additional guidelines for the qualified health plans (QHPs) offered through the health insurance marketplaces (exchanges) established under the Affordable Care Act. We support the Center for Consumer Information and Insurance Oversight's (CCIIO's) efforts to facilitate coverage expansion through the marketplaces by continuing to refine the guidance around QHP networks and believe CCIIO has taken several positive steps in the latest guidance. Many individuals will gain health insurance through this venue and thus, the opportunity for better health. However, we remain concerned that the requirements for including essential community providers (ECPs) in QHP networks are lacking and may leave many of our most vulnerable patients unable to access the providers on which they rely.

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 are ECPs predominately serving the uninsured and patients covered by public programs. Specifically, our members provide a disproportionate share of the nation's uncompensated care and devote more than half of their inpatient and outpatient care to uninsured or Medicaid patients. Our members provide this care while operating on margins substantially lower than the rest of the hospital

essentialhospitals.org
AMERICA'S ESSENTIAL HOSPITALS
1301 Pennsylvania Ave NW Ste 950
Washington DC 20004
t: 202.585.0100
f: 202.585.0101
e: info@essentialhospitals.org

industry—with an average operating margin of 0.88 percent, compared to 5.5 percent for hospitals nationally.[1]

Many of our hospitals' patients are likely to gain coverage for the first time through the marketplaces, and many may transition into and out of marketplace coverage over time. Thus, including ECPs in QHP networks is critical to maintaining patients' access to services and continuity of care as their coverage status changes. Because these low-income patients are generally not as healthy and receive less preventative care and recommended screenings as those with private coverage,[2] they have come to rely on the inpatient, ambulatory, specialty, and critical care services our members provide.

As CCIIO continues to refine the guidance to QHP issuers in the health insurance marketplaces, we ask the agency to consider the following comments.

1. 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 the plan's service area. It is particularly important to include specific requirements around the inclusion of essential hospitals in this requirement to protect reasonable and timely access to vital health services for low-income and underserved patients.

CCIIO should require issuers to offer good faith contracts to all ECPs, and develop specific requirements around the inclusion of essential hospitals.
Essential hospitals are the cornerstone for coordinated care for the nation's low-income and vulnerable populations. These essential hospitals are unique because of the services they provide and the populations they serve. Specifically, essential hospitals:

- Are committed – which they demonstrate through practice – in providing a disproportionate amount of care to vulnerable populations, especially to patients covered by Medicaid or are uninsured;
- Train the next generation of clinicians at levels greater than other hospitals;
- Provide comprehensive, coordinated care to patients in their communities;
- Provide specialized, high-acuity care to patients, often as the sole provider of that care in their community; and
- Advance public health and essential community services.

Essential hospitals are leading providers in their communities as they fulfill their multiple missions and provide care every day to all patients, particularly the most vulnerable. Inclusion of essential hospitals in QHP networks is critical to protect

[1]America's Essential Hospitals Annual Hospital Characteristics Survey, FY 2012. Results to be published.
[2]The Henry J. Kaiser Family Foundation. Key Facts about the Uninsured Population. http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population. Last modified September 26, 2013. Accessed January 26, 2014.

reasonable and timely access to vital health services for low-income and underserved patients. We urge CCIIO to develop further the requirements for the inclusions of essential hospitals in a QHP's network when there is an essential hospital in the QHP's service area.

According to CCIIO's letter, QHP issuers must demonstrate at least 30 percent of ECPs in the plan's service areas are included in the plan's network. Additionally, QHPs 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 the plan's service area. With this new standard for ECP inclusion, CCIIO intends to meet the regulatory standard, established in 45 C.F.R. § 156.235(a), of a sufficient number and geographic distribution of ECPs where available to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in a QHP's service area.

The updated standard enhances ECP inclusion, but it is still not stringent enough to ensure all ECPs are included in provider networks and leaves room for QHPs to continue to exclude the essential hospitals that provide low-income and medically underserved populations the full continuum of care. Currently, only a handful of essential hospitals are included in all QHP networks within their service area. And the majority of our members have reported they have contracts with only a limited number of QHPs. Essential hospitals fulfill such a unique role in their communities that specific guidance around the inclusion of these providers in QHPs' networks is warranted.

CCIIO states that the contracts extended to ECPs should be extended in good faith and should offer terms that a willing, similarly situated, non-ECP provider would accept or has accepted. America's Essential Hospitals supports the agency's guidance for contracts to be offered in good faith to ECP providers and with terms that must be acceptable to a similarly-situated, non-ECP provider. Essential hospitals offer vital services that many non-ECP hospitals do not offer. Thus, rates offered to non-ECP providers are not always sufficient to cover the increased costs that essential hospitals incur due to the multiple missions that they fill.

Currently, one of the major challenges member hospitals have faced is QHPs offering payment rates significantly below the cost of care. CCIIO should monitor contracts offered by QHP issuers to ensure payment rates offered to ECP hospitals are adequate enough to support the unique services, such as trauma and specialty care like neonatal services, these hospitals provide. Adequate payment rates ensure low-income and medically underserved populations continue to have access to care. That access is compromised when payment rates are so insufficient as to exclude ECP hospitals.

For example, the payment rates offered by QHPs to an essential hospital in New York would not cover the hospital's cost of providing care. The hospital already

operates on a tight margin and could not afford to accept the terms. This hospital has the only level I trauma and burn center in its community, which features adult and pediatric trauma and burn units. The hospital also has the only children's hospital with a level IV neonatal intensive care unit (NICU) in the region. This life-saving care will only be accessible at much higher rates or on an emergency basis to all QHP beneficiaries.

A member hospital in Arizona has been excluded from some QHP networks because the issuers have deemed the hospital's services too expensive. The hospital provides a myriad of essential inpatient and outpatient services to its community, including critical adult and pediatric trauma services. More than 700 physicians provide services such as pediatric specialty care, NICU services, radiation oncology, advanced ophthalmic care, and complex orthopedic care. These essential services will be out of network for patients, who will then face higher out-of-pocket costs.

Even those member hospitals that been able to contract with the QHPs in their service areas are concerned about future inclusion, as the payment levels are not favorable now and may decrease over time, which would increasingly challenge their participation. Adequate payment levels are critical to ensuring ECP hospitals are able to provide access to care for low-income patient populations without continuing to face the extraordinary, and unsustainable, levels of uncompensated care present under the current system.

A recent study found QHPs nationwide are utilizing narrow hospital networks as an important cost-control lever, thus limiting patients' access to crucial hospital services and the providers on which they rely. The study also found that QHPs offering broad hospital networks, academic medical centers, and top-performing hospitals tend to have higher premiums.[3] If this continues, patients will have to evaluate the trade-off between paying a higher price to access their longstanding ECP provider or paying less to see someone with whom they have no relationship. Our member hospitals worry about how this choice will impact patient populations seeking their essential hospital services.

America's Essential Hospitals supports the clarification around good faith contracts and encourages CCIIO to elaborate on how that impacts QHP offers to ECPs and essential hospitals. To ensure vulnerable populations continue to have sufficient and timely access to critical hospital services, QHP contracts must adequately and fairly pay for these services—which may not be provided elsewhere in the community. It would be inappropriate for a QHP to offer a disproportionate

[3]McKinsey & Company. Hospital Networks: Configurations on the Exchanges and Their Impact on Premiums. http://www.mckinsey.com/~/media/mckinsey/dotcom/client_service/Healthcare Systems and Services/PDFs/Hospital_Networks_Configurations_on_the_Exchanges_and_Their_Impact_on_Premiums.ashx. Last modified December 2013. Accessed January 17, 2014.

share hospital (DSH) hospital that is part of an academic medical center the same rates as a community hospital and claim it has offered a contract in good faith. **As such, CCIIO should require that QHP issuers 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 essential health services.**

2. CCIIO should ensure patients have access to all hospital services within their plan's network.

CCIIO should evaluate QHPs, through the reasonable access review standard, to ensure that plan networks include hospitals that offer all of the essential services relied on by low-income and medically underserved patients. Network adequacy regulations require issuers to maintain a provider network "that is 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 to enrollees without unreasonable delay" as established in 45 C.F.R. § 156.230(a)(2). This requirement exists to ensure that patients have access to all services, including vital services ranging from primary care to high-end quaternary care that are provided by essential hospitals. In its letter, CCIIO proposes to establish a new process to demonstrate network adequacy that will require QHPs to submit a provider list that includes all in-network providers and facilities for all plans. The agency will review this list according to a reasonable access standard, which CCIIO will establish, that identifies whether patients will have access to all services without unreasonable delay. This standard may include measures of time and distance between providers. CCIIO will focus specifically on the inclusion of providers who have historically raised concerns about network adequacy, such as hospital systems.

As CCIIO determines these standards, it is imperative to note that measuring the number of participating hospital providers in QHP networks does not discern whether or not plan 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 DSH hospitals and academic medical centers provide that 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, CCIIO should undertake a more qualitative review to ensure patients are able to access vital hospital services within their QHP networks.

For example, a key essential hospital in Mississippi has the only NICU in its region, with the next closest more than 60 miles away. However, not one QHP has approached the hospital, and the hospital is not included in any QHP network. In addition to the NICU, the hospital provides health screenings, immunizations, wellness programs, and many other vital community services. Patients also rely on

this hospital for inpatient and outpatient services and countless specialists. If CCIIO does not account for the type of services offered within each QHP network, it could deem this network adequate even without including such essential services as a NICU for many, many miles. And patients who need these essential hospital services will have to find the time and resources—which are scarce—to access that care elsewhere or pay a much higher price.

In other states, members of America's Essential Hospitals have been placed into tiers, which hinders patients' access to all hospital services. The QHPs place providers into different tiers with different reimbursement rates for covered services. Hospitals in preferred tiers have the lowest out-of-pocket costs for patients. 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 were offered a better tier only if they accepted lower reimbursement rates—at levels far below the cost of providing care to their vulnerable patient populations. Typically, these tiers are based on payment rates community hospitals are willing to accept. However, community hospitals do not offer the same types of services as our member hospitals. As a result, many vulnerable patients now face losing access to their established providers and their vital hospital services or paying more out of pocket, which many cannot afford.

Another important aspect of 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, low-income populations. These services reach beyond the walls of the hospital to provide much more comprehensive care to vulnerable populations. Essential hospitals' experience handling such complex medical and social conditions is invaluable to the health of entire communities.

Due to these well-established patient-provider relationships, many patients will likely continue to seek care from their current providers regardless of whether these providers are included in their marketplace plan networks. This tendency was demonstrated during coverage expansion in Massachusetts several years ago. One study demonstrated that patients continued to seek care from their established providers due to a preference for the types of services offered, the affordability of the services, and the convenience of the offered services. Additionally, patients stressed the importance of the nonmedical services, such as translation services, these providers offer. The study also found that essential hospitals continue to be the predominate providers to high-risk patients after coverage expansion, further establishing their importance to the community.[4]

[4]Ku L. Safety-Net Providers After Health Care Reform: Lessons from Massachusetts. *Archives of Internal Medicine.* August 8, 2011;171(15):1379-84.

If patients are unable to access the services essential hospitals provide within their plan networks, they will face additional out-of-pocket costs just to maintain these vital relationships. Others will have to disrupt their care continuum to find new providers. Maintaining standards that could exclude these ECPs from QHPs would only serve to hinder access to vital hospital services for these patient populations. **As such, CCIIO should review patients' access to all essential hospital services within their plan networks during its review of reasonable access to determine QHP network adequacy.**

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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,

/s/

Bruce Siegel, MD, MPH
President and CEO