AMERICA'S ESSENTIAL HOSPITALS

January 12, 2015

Kevin Counihan
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 2016 Letter to Issuers in the Federally Facilitated Marketplaces

Dear Mr. Counihan,

America's Essential Hospitals appreciates the opportunity to submit these comments in response to the above mentioned letter, which offers additional guidelines for issuers offering qualified health plans (QHPs) through the health insurance marketplaces (exchanges) established under the Affordable Care Act (ACA). 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 we believe CCIIO should take additional steps to ensure the inclusion of the full spectrum of providers in the marketplaces. Many individuals have already gained health insurance through this venue and thus, the opportunity for better health. However, we remain concerned that as the marketplaces transition into their second year, the requirements for including essential community providers (ECPs) in QHP networks are still lacking and may leave many of our most vulnerable patients unable to access the providers on which they rely.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Filling a vital role in their communities, our more than 250 member hospitals are ECPs providing a disproportionate share of the nation's uncompensated care and devoting more than half of their inpatient and outpatient care to Medicaid or uninsured patients. A majority of patients at essential hospitals are racial and ethnic minorities, many of whom rely on the culturally and linguistically competent care that only essential hospitals are able to provide. Our

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members provide this care while operating on margins substantially lower than the rest of the hospital industry—with an aggregate operating margin of -0.4 percent, compared to 6.5 percent for all hospitals nationwide.[1]

Many of our hospitals' patients gained 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 its 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.

CCIIO should require issuers to offer good faith contracts to all ECPs and should develop specific requirements around the inclusion of 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 the cornerstone of coordinated care for the nation's low-income and vulnerable populations. 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—to providing care to vulnerable populations, especially patients covered by Medicaid and those who 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.

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[1]Reid K, Roberson B, Laycox S, Linson M. Essential Hospitals Vital Data: Results of America's Essential Hospitals Annual Characteristics Survey, FY 2012. America's Essential Hospitals. July 2014. http://2c4xez132caw2w3cpr1il98fssf.wpengine.netdna-cdn.com/wp-content/uploads/2014/08/VitalData-FullReport-20140804.pdf. Accessed December 23, 2014.
[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 October 29, 2014. Accessed December 23, 2014.

If essential hospitals are excluded from QHP networks, all patients will lose access to these vital health services. For this reason, we urge CCIIO to further develop the requirements for including essential hospitals in QHP networks when they are located in QHP service areas.

The current standard is still not stringent enough to ensure all ECPs are included in provider networks and leaves room for QHPs to exclude the essential hospitals that provide low-income and medically underserved populations the full continuum of care. According to CCIIO's letter, similar to last year's threshold, QHP issuers must demonstrate at least 30 percent of ECPs in the plan's service areas are included in the plan's network. Also, in keeping with requirements in last year's issuers letter, 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. 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 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 QHP networks is warranted. **To this end, CCIIO 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.**

2. CCIIO should monitor QHP contracts to ensure QHP issuers are offering ECP hospitals adequate payment rates that support the complex services they provide.

CCIIO should monitor contracts offered by QHP issuers to ensure payment rates offered to ECP hospitals are adequate to support the unique services, such as trauma, burn, neonatal, and other specialty services, these hospitals provide. Currently, one of the major challenges essential hospitals face is payment rates from QHPs that are significantly below the cost of providing care. 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. However, 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 essential hospitals incur providing these services. These hospitals already operate on tight margins and cannot afford to accept these terms.

What's more, even those essential hospitals that have 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. 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.

According to a recent study, QHPs nationwide utilize narrow hospital networks as a cost-control lever. But because this practice excludes many ECPs, it ends up 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. Accessible, high-quality care should not be a luxury for those who can pay; it should be considered part and parcel of the coverage every American can affordably access. That is the promise of the ACA, but the trend toward narrow networks that exclude ECPs is undercutting that promise.

America's Essential Hospitals supports the clarification around good faith contracts and encourages CCIIO to elaborate on how that impacts QHP offers to ECPs, essential hospitals in particular. 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 share hospital (DSH) 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. **Therefore, CCIIO should review contracts QHP issuers offer to ECP hospitals to ensure these providers are being reimbursed at adequate rates so that low-income and medically underserved populations continue to have access to necessary care.**

3. 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 plan networks include hospitals that offer all of the essential services relied on by low-income and medically underserved patients. CCIIO should also further develop its standards to include specific criteria for determining when a plan's network is deemed adequate. Under the reasonable access standard in its current form, CCIIO will review a provider network during the certification process to ensure it is "sufficient in number and types of providers, including providers that specialize in mental health and substance

[3]McKinsey & Company. Hospital Networks: Updated National View on Configurations on the Exchanges. http://healthcare.mckinsey.com/sites/default/files/McK%20Reform%20Center%20-%20Hospital%20networks%20national%20update%20%28June%202014%29_0.pdf. Accessed December 13, 2014.

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). However, in its guidance, CCIIO does not elaborate on how it will determine when a plan provides access to a sufficient number and type of providers or that the plan offers adequate access to the types of essential services ECPs provide. CCIIO should evaluate QHPs using both quantitative and qualitative criteria that ensure these plans are including providers that offer the full range of primary through quaternary care, including trauma care, public health services, mental health services, substance abuse services, and wraparound services critical to vulnerable patients.

In its letter, CCIIO maintains the process for demonstrating network adequacy that was established for 2015, whereby QHPs submit detailed provider data during certification that include all in-network providers and facilities for all plans. The agency will review this provider data according to a reasonable access standard that identifies whether patients will have access to all services without unreasonable delay. CCIIO will focus specifically on the inclusion of providers who have historically raised concerns about network adequacy, such as hospital systems. CCIIO indicates in the letter that it will develop future network adequacy standards based on information gleaned from the certification process, in addition to the results of a workgroup of the National Association of Insurance Commissioners that is revising the Managed Care Network Adequacy Model Act.

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 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.

During the review process, CCIIO should scrutinize tiered networks to ensure ECPs being placed in tiered network arrangements are being reimbursed sufficiently to cover their cost of providing complex care. CCIIO also should determine whether a QHP's network is adequate by evaluating only the providers included in the lowest cost-sharing tier. Furthermore, the agency should evaluate plan networks to ensure issuers do not arbitrarily place certain hospitals in higher cost-sharing tiers and that the same benefits are available to patients across tiers in a QHP. In many states, members of America's Essential Hospitals have been placed in tiers that 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 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 network 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 predominant providers to high-risk patients after coverage expansion, further establishing their importance to the community.[4]

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. Merely counting the number of hospitals or other providers in a network plan does not account for the types of specialized services essential hospitals provide. **As such, CCIIO should conduct a qualitative review of QHPs during its reasonable access review to ensure QHPs include ECP hospitals that are uniquely suited to offer highly complex services to a diverse set of**

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

patients. In doing so, CCIIO will ensure patients have access to the full range of essential hospital services within their plan networks.

4. CCIIO should implement standards requiring publicly available provider directories that display specific information useful to consumers in choosing a health plan.

CCIIO should implement standards requiring issuers to file publicly accessible provider directories that contain information useful to consumers who are choosing a health plan. America's Essential Hospitals supports a proposal by the Centers for Medicare & Medicaid Services (CMS) that will encourage the use of accurate and regularly updated provider directories. CMS included requirements around provider directories in a proposed rule on 2016 marketplace plans,[5] and CCIIO mentions these proposals in the letter as a step toward ensuring transparency and facilitating consumer choice. The proposal would add to the network adequacy regulations at 45 C.F.R. § 156.230(b) by requiring provider directories to contain specific information on providers, such as their location, specialty, institutional affiliations, and whether they are accepting new patients. Under the proposal, the directory will also have to clearly identify the plans and networks in which providers are participating. Provider directories often contain inaccurate or incomplete information, so requiring issuers to follow these guidelines will be useful in helping consumers understand all of the factors involved in their insurance plan. **Therefore, CCIIO should enforce provider directory requirements to provide consumers with clear information they can use to choose plans that allow them to access the care they need.**

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America's Essential Hospitals appreciates the opportunity to submit these comments. If you have any questions, please contact Xiaoyi Huang at 202-585-0127.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO

[5]Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; 79 Federal Register 70674 (November 26, 2014)