American Hospital Association™
Advancing Health in America

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August 30, 2021

Elizabeth Fowler, Ph.D, J.D.
Deputy Administrator and Director
Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Dear Dr. Fowler:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) thanks you for meeting with us and discussing your plans for the next decade of the Center for Medicare and Medicaid Innovation (CMMI).

We were pleased to read your Aug. 12, 2021 *Health Affairs* blog post, "Innovation At the Centers For Medicare And Medicaid Services: A Vision For The Next 10 Years," and learn about the results of the strategic review you and your team conducted. We strongly support your plans to drive accountable and innovative care, advance health equity and address affordability for patients. We also support your plan to engage in partnerships to achieve system transformation. We stand ready to serve as one of your partners to implement alternative payment models that best serve patient and provider needs. To that end, we write today to share some specific ideas on ways to extend access to high-quality, accountable care to all patients in all locations.

In addition to the topics covered below, we are working with member hospitals and health systems to explore and develop solutions to patient challenges with health care billing. We know this is one of the most frustrating parts of patients' health care experience, and hospitals and health systems are committed to finding workable solutions. These solutions will require engagement from many different stakeholders, including patients, providers, health plans and government. We look forward to following up with you in the coming months on this important work, including with an invitation to be a part of a multi-stakeholder effort to develop solutions.

ENSURING ACCESS TO CARE IN RURAL AMERICA

Access to health care is an essential component of maintaining good health and well-being. The millions of Americans living in rural communities depend upon their hospital as an important, and often the only, source of care. The nation's nearly 2,000 rural community hospitals frequently serve as the anchor for their area's health-related services, often providing prevention and wellness services, as well as community outreach and employment opportunities. This has been evident during the COVID-19 pandemic, in which rural providers have led the testing and public health messaging in their own communities, as well as treating non-COVID-19 patients from other hospitals that were overwhelmed with complex COVID-19 cases.

These rural communities and their hospitals face many challenges. Rural hospitals often struggle with their remote location, limited workforce and constrained resources. However, many of these hospitals are fighting to survive – potentially leaving their communities at risk for losing access to local health care services. For example, as of June 2021, 138 rural hospitals have closed since 2010, forcing many people in rural communities to travel even further to receive care that they need, and in some cases delay or forgo health care entirely. Simply put, the loss of a rural hospital can be devastating to the individuals living in these communities.

Rural and underserved communities have diverse challenges and opportunities that may change over time. These include persistent challenges such as low patient volume and workforce shortages; recent challenges such as high drug costs and increased regulatory burden; and emergent challenges such as cyber threats, the opioid epidemic and the pandemic. In response, providers are seeking ways to transform their care delivery in order to continue meeting their community's needs. **Therefore, as CMMI focuses on developing new and continuing existing innovative care models, we recommend that it establish a Rural Design Center to focus on rural issues and models that may improve access to care, health outcomes, patients' experience of care and affordability.**

This recommendation was part of AHA's Future of Rural Health Care Task Force report, released in May 2021. As envisioned by the Task Force, a Rural Design Center would focus on smaller-scale initiatives to meet the needs of its communities and encourage participation of rural hospitals and facility types. For example, it would focus on models that do not rely on patient volume or other measures that typically exclude rural providers. This would provide an opportunity for rural hospitals to innovate at the local level. In addition, it would use a group of rural stakeholders and experts, with representation from payers, technology experts, academics and providers working in rural areas, to work in conjunction with CMMI to design and adapt projects that would increase participation from and applicability to rural hospitals and providers. Such a Rural Design Center would help develop and increase the number of new rural-focused CMMI demonstrations, expand existing rural demonstrations and create separate rural tracks within new or existing CMMI models. For example, CMMI released a new

payment model, Community Health Access and Rural Transformation (CHART), for rural hospitals in August 2020 that provided increased financial stability through upfront payments. This model is an example of the type of model that the Design Center might develop or expand on a broader scale.

As an initial priority area, we urge that the Rural Design Center consider rural maternal care. As outlined in the AHA report, maternal health care continues to be a significant challenge for many rural providers as they continue to face financial and operational burdens. More than half of all rural U.S. counties lack hospital obstetric services[1], with many hospitals facing low volume in this service line, making recruitment and retention of obstetricians and gynecologists difficult, among other reasons. In addition, rates of maternal morbidity and mortality are notably higher for rural residents.[2] CMMI could further disseminate state innovations and best practices around rural maternal care, and the Rural Design Center could support the creation of innovative rural payment models. For example, it could expand the Pioneer Baby Model, which began in Kansas six years ago aimed at improving pregnancy and birth outcomes among mothers with gestational diabetes, to include other pregnancy-related conditions and other rural communities.

ENSURING ACCESS TO CARE FOR HIGH-NEED URBAN PATIENTS

Over the past 18 months, COVID-19 has ravaged the nation. The pandemic – still ongoing in many locations – hit cities across the country very hard. These urban hotspots are home to many Americans who have complex medical and social needs. These individuals are generally low-income, racially and culturally diverse, often reliant on extensive social services, and challenged in accessing health care. And the complexity of these patients' needs has only increased as a result of a pandemic that was particularly difficult for the populations that lacked the resources to escape it.

During the pandemic, and for decades prior, hospitals in these urban locations have served as anchors in their communities without sufficient funding to ensure their long-term viability. They provide a critical point of access for primary and specialized health care services and serve as trusted partners in improving community health through relationships with schools, civic and religious organizations, and community leaders. They also serve as the de-facto public health entity in their areas, a role that greatly ballooned during the COVID-19 pandemic. These hospitals serve a significant number of Medicare, Medicaid and uninsured patients and are therefore largely dependent on underfunded government payers and patients unable to pay for care. This leaves these critical facilities without necessary funds to repair and modernize their crumbling infrastructure and makes them susceptible to closures. That these hospitals have been

[1] Health Affairs. (2017). Access to Obstetric Services in Rural Counties Still Declining, with 9 Percent Losing Services, 2004-14. https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0338
[2] Health Affairs (2019). Rural-Urban Differences in Severe Maternal Morbidity and Mortality in the US, 2007 – 2015. https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00805

allowed to languish without additional federal support only underscores their role as supporters of historically marginalized communities.

Yet these vulnerable urban hospitals are the lifeblood of their communities, and, as such, it is critical that they not only survive, but thrive. Many of these hospitals are more likely to provide certain essential services (e.g., trauma care, burn unit, neonatal intensive care unit, pediatric intensive care unit, alcohol and chemical dependency services, HIV/AIDS services) and their closure could spell the end of patient access to these services in their communities. To truly address the health inequities that plague the communities served by these hospitals, and to ensure vulnerable urban hospitals can continue to provide high quality care to all patients, regardless of ability to pay, they need more funding, better funds flow, and the flexibility to innovate. This also is critical to enabling vulnerable urban hospitals to simultaneously improve their infrastructure, make sound energy and environmental enhancements, and better serve communities in need. These hospitals simply do not bring in enough funding from all payers to cover the expense of caring for high-needs populations that have long suffered from health inequities.

That is why the AHA has brought together a subset of our vulnerable urban hospital members to develop ideas for how to ensure patients will not lose the anchor hospital in their communities. Specifically, we are working on creating a proposal for a specific legal designation for these hospitals and a corresponding payment demonstration to ensure their sustainability. **We welcome an opportunity to discuss this work with you and, as you continue your strategic review of the direction of CMMI, urge you to consider the role hospitals play in historically marginalized communities, especially in times of disaster, and to ensure their viability is factored into current and future CMMI models.**

STRENGTHENING THE FUTURE OF PRIMARY CARE

The AHA strongly supports and commends CMMI's efforts to ensure its models move the health care system toward a situation in which every patient has a team of providers that are meaningfully accountable for the quality of their care, including access to care coordination and navigation services, as well as for the cost of that care. We also support your renewed focus on advanced primary care and your efforts to center primary care providers in this sphere of accountable care.

As providers of cross-spectrum care, hospitals and health systems greatly contribute to primary care delivery. As such, the AHA and our members are exploring innovative ways to reimburse for primary care so as to ensure patient and provider satisfaction, quality of care, the maintenance of an adequate workforce, and resiliency against disruptions in anticipated utilization as occurred during the COVID-19 pandemic. This is especially important in rural areas that have long experienced a shortage of primary care providers, made worse by the pandemic. **We are currently exploring whether some form of prepayment – such as capitation – would enable primary care**

providers to deliver high-quality, lower cost care to their patients. We would welcome an opportunity to share with you the results of our work as it is completed.

IMPROVING THE AFFORDABILITY OF CARE FOR PATIENTS

Patients are increasingly being asked to shoulder more of the cost of their health care through complex cost-sharing structures with the potential for substantial negative impacts on their health and financial wellbeing. Higher cost-sharing contributes to more delayed and avoided care, which has been shown to contribute to worse health outcomes. Oftentimes, those least able to pay are enrolled in high deductible health plans as these plans appear cheaper upfront. However, the higher cost-sharing can leave many patients with unaffordable medical bills. The complexity of cost-sharing also is a barrier to care. Patients struggle to navigate the interaction between copayments, deductibles and coinsurance, and because deductible and coinsurance amounts may not be known until after a service is complete, these types of cost-sharing structures can create financial uncertainty and stress for patients.

The United States is unique in its use of cost-sharing – both in terms of the total amount patients are expected to pay out-of-pocket, as well as the complexity of the rules related to cost-sharing. **We recommend that CMMI establish several new demonstration projects to test whether different benefit structures may improve access to care, health outcomes, patients' experience of care and affordability.** Two specific models that CMMI could consider include:

- **Alternative Benefit Designs.** CMMI could conduct a demonstration to test alternative health insurance benefit design structures to determine whether lower patient cost-sharing positively impacts patient access to care and health outcomes, as well as health care affordability. Specifically, CMMI could test three different benefit designs: 1) one that is fully financed through premiums and has no patient cost-sharing, 2) one with very limited patient cost-sharing (e.g., plans with an actuarial value standard between 95% - 98%), and 3) one that relies solely on clear copayment amounts without coinsurance or deductibles.

- **Transition Patient Cost-sharing Collection to Insurers.** Health insurers' primary function is to help finance health care through pooling costs, managing risk and paying claims. They negotiate rates with providers and set patient cost-sharing amounts. As noted above, the amount and complexity of patient cost-sharing can create barriers in patient access to care, and it is imperative that we reduce those barriers. One way to achieve this would be to remove any financial transactions between patients and providers. Cost-sharing could continue to exist, but it would be assessed and collected by health plans instead of providers. This approach offers several benefits in addition to removing a potential upfront financial barrier to care. It also would consolidate all patient billing in a single place, eliminate multiple bills for a single episode of care,

eliminate any opportunity for unanticipated bills as providers would no longer bill directly any insured patient, and it would reduce the complexity of cost-sharing as a single entity – the plan – would coordinate and assess the cost-sharing obligation. Legislation pursuing this approach has been introduced in Colorado and is under discussion in several other states.

Again, we thank you for your consideration of our ideas. Please contact me if you have questions, or feel free to have a member of your team contact Shira Hollander, senior associate director of payment policy, at 202-626-2329 or shollander@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development