American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

January 30, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Request for Information; Essential Health Benefits (CMS-9898-NC)

Dear Administrator Brooks-LaSure:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 90 that offer health plans, and 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, we thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) request for information on Essential Health Benefits (EHB) under the Patient Protection and Affordable Care Act (ACA).

Patients must be able to rely on their health care coverage to facilitate access to needed care. As such, the ACA required that qualified health plans (QHPs) sold on the Health Insurance Marketplaces (Marketplaces) and certain other health plans offer their enrollees sufficient access to a comprehensive set of services and providers. In addition, these plans' benefit structure — the services they cover and at what cost-sharing — must not discriminate against enrollees based on age, health conditions or sociodemographic factors. The ACA codified these requirements under the EHB and network adequacy provisions.

Since the ACA's inception, AHA has supported the intent of the EHB requirements and subsequent efforts to strengthen them. We commend CMS for seeking stakeholder input on potential modifications to these requirements, and we specifically focus our comments on the following issues: behavioral health; maternity, infant and pediatric care; health equity and access; and health plan policies that may restrict patient access to EHBs. While we do not provide detailed comments on prescription drug access, we

recognize that such benefits are vital for patients. As CMS considers potential changes to the current EHB drug classification system, we urge the agency to ensure that any updates to the current drug classification system, including adoption of USP Drug Classification (USP DC), revolve around a transparent and comprehensive process that is focused on the best interest of patients.

BEHAVIORAL HEALTH

Behavioral health services are generally one of the areas of care that patients struggle most to access. While there are multiple causes, including a dearth in the supply of providers, coverage rules certainly play an important role. While plans subject to the EHB requirements must cover mental health and substance use disorder services, specific benefits vary by state and plan. This variation presents a particular challenge to individuals seeking coverage because covered mental health and substance use disorder services are generally listed on plan benefit summaries only as “outpatient” or “inpatient” with little further specificity. Certain plans may explicitly limit or include exceptions for services such as partial hospitalization, group therapy or intensive outpatient treatment; others may not. Some plans may apply prior authorization for certain services; others may not. Not all plans are clear about cost-sharing requirements, with some benefit summaries merely listing “additional charges may apply” for inpatient or outpatient services. There are no filters in the health plan search tools to account for these differences.

The lack of specificity in coverage allowances not only makes it difficult to discern whether certain services are covered, it makes it difficult to determine if they are *adequately* covered. A particularly striking example is emergency behavioral health services, including mobile crisis care and stabilization services. The availability and reliability of crisis stabilization services vary widely by jurisdiction, challenging patients’ ability to determine what services are actually available to them through the various coverage options sold in their communities.

AHA recommends CMS improve the specificity of what mental and behavioral health services are included in the EHBs and explicitly list services of most interest to patients: individual psychotherapy, group therapy, partial hospitalization services, intensive outpatient services, crisis transport and stabilization services, and peer support and recovery. Plans should include this list of covered services as they do prescription drugs in their plan benefit summaries. For reference, plans could review the list of HCPCS H-codes representing a standardized set of behavioral health services. In addition, plans should be required to identify when a service is subject to a utilization management requirement, such as prior authorization.

MATERNITY, INFANT AND PEDIATRIC CARE

Improving the health of mothers and children is a top priority for the AHA and our member hospitals and health systems. Eliminating maternal mortality, reducing severe

morbidity and reducing disparities in care and outcomes for mothers and babies are of particular concern. **As CMS and HHS look to update and improve the policies pertaining to EHBs for maternal and infant care, the AHA recommends that maternal and infant benefits cover services provided by non-physician clinicians and other non-clinical practitioners in maternal and postpartum care for mothers and infants.** Examples include non-physician clinicians such as midwives, nurse practitioners (NPs), and non-clinical practitioners such as doulas, to assist in maternal and postpartum care. Studies have shown that using doulas, for example, can improve outcomes for mothers and infants, especially for women at risk of adverse outcomes, including Black and Latina women. Doulas have demonstrated a reduction in labor time, a reduction of a mother's anxiety, improvements in mother-baby bonding post-birth and improved breastfeeding success.[1]

In addition to expanded benefits to include non-physician clinicians and other practitioners, telehealth has proven essential in providing maternal care. During the COVID-19 pandemic, telehealth visits allowed supported care throughout the perinatal period, kept patients safe during their pregnancy, and allowed consultations with specialists when needed. Access to telehealth services was particularly beneficial for patients in both urban and rural areas with no or limited access to obstetric providers. Telehealth visits also allow in-home monitoring of the physical conditions of mothers and babies and monitoring of depression or other mental health conditions the mother could be facing**. The AHA recommends that reimbursable telehealth visits be included in the EHBs for maternity and infant care.**

Regarding pediatric EHBs, such benefits must allow children and adolescents access to timely and age-appropriate care. Timely access is particularly the case for pediatric behavioral health providers, as discussed in the previous section on improvements to behavioral health essential benefits.

HEALTH EQUITY AND ACCESS

The agency asks for feedback on how EHB policy could advance health equity. The basic concept of EHB — that is, to provide a minimum set of health care items and services that QHPs must cover for all enrollees — is intrinsically linked to health equity. However, the full promise of EHB in advancing health equity can only be realized if enrollees are empowered to know and understand the specific ways their plans are implementing their benefits, as well as to ensure that plans are not placing inappropriate restrictions on EHBs. Limited English-language proficiency and low health insurance literacy can serve as major barriers to patients selecting the coverage that best meets their needs. As administrators of a public benefit, QHPs have a core responsibility to

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[1] "Impact of Doulas on Healthy Birth Outcomes," accessed at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/

ensure their plans and benefit designs are easily accessible and understandable to all enrollees.

We urge CMS to prioritize the development of policies and programs that ensure plans are delivering their services in linguistically and culturally appropriate ways, as well as on a non-discriminatory basis. For example, CMS has recently proposed several changes to the requirements for its Medicare Advantage plans that are intended to advance health equity; the agency could consider adopting similar requirements for plans on the Marketplaces. Among other policies, CMS could expand the list of populations to which plans must provide culturally appropriate services and ensure plans offer digital health education to access telehealth benefits.

BARRIERS TO ACCESSING COVERED SERVICES

Certain health plans are erecting unnecessary barriers to care that have direct negative impacts on patient health and the health care workforce. This includes improper use of utilization management programs, inappropriate denials of medically necessary covered services, overly restrictive medical necessity criteria that are not transparent to patients or providers, unnecessary and unreasonable documentation requirements, and mid-contract year changes to patients’ coverage (such as where patients may access certain services, like surgeries or diagnostics). The AHA is increasingly concerned these plan policies are inappropriately restricting or delaying patient access to EHBs, while adding cost and burden to the health care system. In short, such plan policies may have the effect of curtailing the benefits of the EHB requirements.

Patients should be able to rely on their coverage to facilitate access to medically necessary health care services, especially EHBs, when they need them, without delays or inappropriate denials, and clinicians should be able to focus on caring for patients without burdensome obstacles. Hospitals and health systems report that prior authorization and other utilization management tolls are increasingly applied to a wide range of services, including those for which the treatment protocol is long-established and clear and there is no evidence of abuse. The resulting denials can cause delays in necessary treatment for patients and require doctors and nurses to go through onerous and duplicative appeal processes to rectify inappropriate coverage denials. Similarly, health plans also often force patients to suffer through periods of ineffective treatment before permitting access to the most appropriate therapy. Use of step therapy or fail-first policies is increasing, and the inappropriate application of these policies often puts quality of care at risk.

Overall, there is mounting evidence that these problematic health plan practices are growing. Government agencies, as well as courts and arbitrators, have continued to

uncover concerning findings with respect to certain commercial insurer conduct.[2] It is increasingly clear that some health plans are pursuing a strategy of denying appropriate care to avoid legitimate payment obligations, and greater oversight and accountability is needed to prevent unfair insurer practices and ensure appropriate patient access to EHBs and other covered health services.

The AHA commends CMS for recent proposals[3] that would streamline prior authorization rules in many forms of coverage. **We urge the agency to ensure adequate oversight of health plans to address instances of inappropriate prior authorization and payment denials and ensure fair coverage of EHBs for patients and providers.** This includes conducting routine oversight and evaluating plan-level performance metrics to ensure that patients have timely access to covered EHBs, that plans do not place excessive burdens on providers to comply with such utilization management techniques, and that critical health system resources are not squandered by costly administrative requirements that do not add value.

We thank you for your consideration of our comments. Please contact me if you have questions or feel free to have a member of your team contact Molly Smith, AHA's group vice president of public policy, at mollysmith@aha.org or 202-626-4639.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis and Development

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[2] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp
https://www.beckerspayer.com/payer/5m-fine-against-bcbs-largest-in-georgia-regulator-s-history.html
[3] https://www.federalregister.gov/documents/2022/12/13/2022-26479/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability and
https://www.federalregister.gov/documents/2022/12/27/2022-26956/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program