



Charles N. Kahn III
President and CEO

January 27, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023 [CMS-9911-P]

Dear Administrator Brooks-LaSure:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. The FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services. The FAH appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding its proposed rule on the *HHS Notice of Benefit and Payment Parameters for 2023* (Proposed Rule) published in the Federal Register (87 Fed. Reg. 584) on January 5, 2022.

Network Adequacy and Essential Community Provider Standards (Part III.E.11 & 12, 45 C.F.R. §§ 156.230, 156.235)

The FAH strongly supports CMS's proposals regarding network adequacy and essential community provider (ECP) requirements. Meaningful network adequacy requirements are critical to ensuring that qualified health plan (QHP) enrollees have sufficient access to quality, affordable care and thus receive value for their coverage. Moreover, ECP standards complement

network adequacy requirements and promote health equity by ensuring that QHPs contract with a sufficient number of providers that serve predominately low-income and medically underserved individuals. Recognizing that Exchange-based coverage would be of little value if it did not provide consumers with access to robust, quality provider networks, Congress required the Secretary to establish criteria for the certification of QHPs that “ensure a sufficient choice of providers” and include within QHP networks “those essential community providers, where available, that serve predominately low-income, medically-underserved individuals.”¹

With respect to network adequacy, CMS proposes to evaluate the adequacy of federally facilitated Exchange (FFE) QHP provider networks, consistent with the decision of the United States District Court for the District of Maryland in *City of Columbus v. Cochran*, 523 F. Supp. 3d 731 (D. Md. 2021), and to adopt network adequacy standards for FFE QHPs by imposing time and distance standards, appointment wait time standards, and standards related to tiered networks. In addition, CMS proposes increasing the required ECP provider participation standard from 20 percent to 35 percent of available ECPs and to adopt ECP standards related to tiered networks. ***The FAH supports promoting patient access to appropriate care through the proposed network adequacy requirements and ECP standards set forth in the Proposed Rule.*** Insurance that does not provide access to high quality and affordable care harms patients that forego needed care and erodes consumer confidence in the value of coverage more generally.

In particular, the network adequacy standards proposed are consistent with CMS’s experience with federal health care programs (particularly Medicare Advantage) and stakeholder feedback that CMS acquired over eight years of administering FFEs. Time and distance standards have long been a critical component of Medicare Advantage network adequacy standards, and the proposal would appropriately apply county-specific time and distance parameters particular to different types of practitioners and facilities. Appointment wait time standards are also a common and important element of network adequacy requirements, and the FAH supports the proposal to focus on wait times for providers and facilities that offer behavioral health services, routine primary care, and non-urgent specialty care.

The FAH also supports CMS’s proposal to require a QHP that uses tiered networks to satisfy the quantitative network adequacy and ECP requirements based on the QHP’s network of providers and facilities in its lowest cost-sharing tier. Because patients rely on the network of providers in the lowest cost-sharing tier when seeking to access care, ECP and network adequacy requirements should properly focus first and foremost on those providers included in the plan’s lowest cost-sharing tier. In addition, the proposed approach ensures that particular specialties or facility types are not relegated to a higher cost-sharing tier in ways that diminish access to certain types of care.

The FAH is concerned, however, that CMS does not propose to include post-acute rehabilitation programs, such as inpatient rehabilitation hospitals and units (IRFs), comprehensive outpatient rehabilitation facilities (CORFs), or long-term care hospitals (LTCHs), in the list of facility specialty types to be evaluated during network adequacy reviews. Omitting these post-acute programs from network adequacy review undermines patient access to these critical settings of care. In fact, CMS includes IRFs and CORFs as a covered benefit under

¹ ACA § 1311(c)(1)(B)-(C), 42 U.S.C. § 18031(c)(1)(B)-(C).

traditional Medicare, and hundreds of thousands of Medicare enrollees benefit from treatment from these providers annually.

The FAH urges CMS to include IRFs, CORFs, and LTCHs as part of its network adequacy review process. This will promote access to appropriate rehabilitation services and avoid inappropriate diversion of patients to nursing homes because their health plans do not contract with a sufficient number of rehabilitation providers. Too often, enrollees with brain injuries, spinal cord injuries, those who have sustained strokes, and others with a variety of complex but common conditions do not receive the intensive, longer-term services they need because health plans do not contract for these specialized services. Further, inadequate specialty networks exacerbate health equity issues for patients who are already facing disparities in access to health care.

Solicitation of Comments—Impacts of Stronger Network Adequacy Standards (Part III.E.11.c.vi)

The FAH is deeply concerned with CMS’s view that network adequacy standards could be “leveraged to create an uneven playing field in network agreement negotiations that could result in higher health care costs for consumers.”² Network adequacy standards—including time and distance and wait time standards—are common features of managed care regulations, and the proposed standards are generally consistent with standards used for plans in the Medicare Advantage program. Decades of experience with time and distance and appointment wait time standards confirm that these requirements are a necessary component of health plan regulation that protect patients and promote access to care. The Proposed Rule does not provide any support for the assertion that consumer harm could result from the application of these network adequacy standards to QHPs. In addition, the Proposed Rule does not offer any explanation as to why it believes that the antitrust laws passed by Congress and enforced by the Federal Trade Commission (FTC) and the Department of Justice (DOJ) Antitrust Division are insufficient to promote competition amongst health care providers and facilities.

In the Proposed Rule, CMS solicits comments on a potential rule that would limit contracting by multi-provider health systems on an “all-or-nothing” basis.³ The FAH strongly opposes the imposition of such a rule because of the significant risk that it would harm patients by fragmenting care, promote abuse by insurance carriers, and adversely impact the Exchanges (or Marketplaces). In addition, the suggestion that network adequacy requirements inappropriately provide “leverage” to health care providers is inconsistent with prior experience with network adequacy standards in other programs, comments on the implementation of the

² 87 Fed. Reg. at 684.

³ The Proposed Rule also solicits comments on a potential rule that would circumscribe contractual steering provisions, but the FAH cannot provide feedback on this request because it is unclear what CMS considers to be a steering provision. For example, the FAH would oppose any proposal that limits the ability of QHP issuers and providers to negotiate discounted rates that are contingent on the provider’s inclusion in the QHP’s lowest cost-sharing tier for that provider type. These types of contractual provisions promote competition among providers and allow issuers to obtain price concessions that decreases the health care costs for consumers.

court's decision in *City of Columbus v. Cochran*, 523 F. Supp. 3d 731 (D. Md. 2021),⁴ and Congress's express instruction that HHS establish network adequacy standards for QHPs.

Health systems play a critical role in coordinating patient care and promoting value-based care, and provider contracting at the health system level supports improved and integrated patient care across multiple provider types at lower costs to consumers. Health systems have long been at the forefront of creating integrated delivery systems that minimize the duplication of services while improving patient outcomes and the experience of care. Hospital-based health systems have added and built lower cost sites of services for both pre- and post-acute care in an effort to better coordinate the entire continuum of care for patients and meet patient needs in their communities. For example, some health systems provide clinically based care navigation for high risk obstetric, cardiology, orthopedic, behavioral health, and oncology patients, among others. These programs follow patients through the continuum of care in several settings, simultaneously improving quality of care and efficiency. Realizing the value of these initiatives depends on health systems contracting with payers on an integrated and coordinated basis. A Federal rule that requires permitting QHP issuers to cherry pick amongst the components of a health system reduces integrated systems to fragmented, a la carte options that deteriorate patient quality of care and creates risk – reversing course on other HHS and CMS policies to drive accountable care.

Beyond the risk of eroding high-quality, integrated care, prohibiting health systems from contracting as integrated providers presents the risks of inefficiencies in care and increased consumer costs. Health systems are able to offer more significant discounts and better value when they contract on a system-wide basis across the continuum of care as opposed to entering into piece-meal contracts that are specific to particular services or locations. In addition, health systems appropriately use full system contracts to facilitate investment in services needed in the community. When a health system builds new locations or expands programs and service lines, it takes on significant financial risk in order to ensure access to needed services in the community. System-level contracting facilitates these investments in service lines and facilities—including in underserved rural communities, while also ensuring that the community can actually access new services and facilities on an in-network basis. In short, system-level integration promotes marketplace efficiencies and fosters competition for integrated delivery systems, and limitations on integrated contracting would reduce this critical dimension of competition to the detriment of consumers.

These concerns are magnified as the line between payer and provider has blurred in recent years. A growing number of health insurance carriers acquire and operate a large number of provider sites. QHP issuers that are under common ownership or control with health care

⁴ Last year, CMS solicited comments related to network adequacy requirements in light of the decision in *City of Columbus*, and it summarized these comments in Part 3 of the 2022 Payment Notice final rules. Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond, 86 Fed. Reg. 53,412, 53,446 (Sep. 27, 2021). Based on these comments, HHS expressed its intent to adopt network adequacy standards that are informed by those used in Medicare Advantage and reflect real-world barriers to access (including physical barriers). The summarized comments do not raise the concerns expressed in the Proposed Rule.

providers have a financial incentive to design plans for their own financial benefit, driving patient volume to their affiliated providers for profitable service lines while contracting with unaffiliated providers only to fill gaps. This strategy is often pursued even though the affiliated providers may have higher costs because driving patient volume to affiliates keeps a larger share of premium revenue with the QHP issuer and its affiliates. A rule prohibiting integrated contracting by health systems would accelerate these trends, reducing consumer choice and price-based competition in the marketplace.

In short, integrated health system contracting with plans has pro-competitive and pro-consumer benefits and reducing contracting at the health system level risks unintended market harms. And in circumstances where contracting strategies or other activities reduce payer or provider competition, Federal antitrust laws provide the appropriate framework for addressing anti-competitive conduct. Finally, experience in the Medicare Advantage program and with the Exchanges confirms that network adequacy standards—including time and distance and appointment wait time standards—protect consumers, ensuring that their premium dollars provide access to quality, affordable care.

Standardized Option Definition (Part III.E.10, 45 C.F.R. § 156.201)

CMS proposes to resume requiring issuers of QHPs in FFEs and State-Based Exchanges (SBEs) on the Federal Platform to offer standardized plan options beginning in PY 2023. Issuers on those Exchanges would need to offer a standardized option at every product network type, metal level, and in every service area for which an issuer offers one or more non-standardized plans. If an issuer is in a state that already requires standardized options under State law, those issuers would not be subject to the federal requirements.

FAH supports Exchange policies that are intended to ensure that consumers have a robust choice of plans that offer a variety of benefits while at the same time simplifying choices for beneficiaries so that comparing options is feasible. We agree with CMS that the proposed standardized options can play a role in enhancing consumer experience. However, standardization that limits the plans consumers are offered does not benefit consumers. We do not agree with CMS's concern that the number of plan options has risen along with rising Exchange enrollment. On the contrary, we believe that the increasing number of plan choices indicate an increasingly robust market where issuers and providers have the flexibility to innovate, and consumers are able to enjoy a wide range of options. Therefore, we would not support CMS imposing, in future rulemaking, a limitation on the number of non-standardized QHPs that may be offered as a method for addressing choice overload.

In requiring standardized options, it is extremely important that CMS settle on standard options that provide meaningful coverage to consumers. As in earlier regulatory proposals on standardized plans, CMS based its standardized options on the most popular Exchange QHPs (in this case, for 2021). While it may be reasonable to base the proposal on popular plans, the FAH suggests that a QHP's popularity with consumers at initial enrollment may not be the best way to identify a federally required standard plan option. Popularity of plans can change radically from year to year since popularity often highly correlates to the lowest premium plans offered each year. Instead, CMS should make data available that provides insight into the consumer experience with those plans, including consumer experience with network and hospital and

provider access, as well as out-of-pocket spending and service usage. Without additional data, it is difficult to determine whether the proposed standard options are sufficient.

We support the differential display of standardized options including requiring QHP issuers and web-brokers to differentially display standardized options when a non-FFE Web site is used to facilitate enrollment. A differential display or some kind of unique labeling to indicate to the consumer that a plan reflects standardized features would facilitate plan shopping and help inform consumers about the distinctive cost sharing features of plan choices. CMS could require special labeling, for example by using a phrase such as “simple choice” option as was required in prior rulemaking. We support providing a way for consumers to distinguish those options from non-standardized options, and to be able to filter plan options based on whether or not they are standardized options. We believe this would help consumers to understand how standardized options differ from non-standardized options and make more informed choices of plans that best meet their own needs.

Thank you for the opportunity to comment on the Proposed Rule. If you have any questions, please contact me or a member of my staff at 202-624-1534.

Sincerely,

A handwritten signature in black ink, appearing to read "Shirley K. [unclear]". The signature is fluid and cursive, with a large initial 'S' and a long horizontal stroke at the end.