



Charles N. Kahn III  
President and CEO

January 31, 2023

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: Request for Information on Essential Health Benefits (CMS–9898–NC)**

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.

We are writing in response to the Centers for Medicare & Medicaid Services' (CMS) request for information (RFI) on Essential Health Benefits (EHB) and the EHB package required of all non-grandfathered individual and small group health insurance coverage. In previous comments on EHB and additionally in the context of Medicare Advantage and Medicaid, the FAH has previously expressed concerns about health plans' inappropriate use of prior authorization and other forms of utilization management, and limitations on behavioral health, inpatient medical rehabilitation, long term acute care hospital, and other necessary services. We appreciate the opportunity to raise these concerns in the context of EHB since excessive utilization management of essential benefits can undermine efforts to ensure plans provide

essential benefits. We are encouraged by CMS’ interest in addressing these access issues across various payers and plans, and we urge CMS to quickly lay out plans to address shortcomings in EHB oversight and ensure that EHB affords enrollees improved access to care.

### **Barriers to Accessing Services**

Plans’ excessive use of unique prior authorization criteria and limited networks are creating barriers to access of EHBs and are perpetuating certain disparities. Our members have noted that inpatient rehabilitation and mental health and substance abuse services are at particular risk.

The FAH has significant concerns about plans that are compliant on paper with EHB requirements but then use utilization management techniques to limit access to those EHBs. For example, many plans use highly restrictive criteria to keep patients out of inpatient rehabilitation facilities and inpatient long term acute care hospitals. Some plans rely heavily on algorithms that lead to prior authorization and claims payment denials – often after the care has been provided. The use of these algorithms can have the opposite impact from what CMS would hope to achieve in addressing care disparities. To the extent these algorithms are based on historic biases, appropriate patient care could be in jeopardy and disparities continued. Some plans also deny emergency room visits for mental health or behavioral health emergencies because prior authorization was not received in advance of receiving care.

The FAH is encouraged by CMS’ recent proposal to update regulations in order to streamline prior authorization processes across multiple plans types, including qualified health plans (QHPs) on the federally facilitated exchanges (FFE). According to CMS’ own estimates, this will save providers \$15 billion over 10 years in administrative burden.<sup>1</sup> The proposed rule also requires—beginning March 31, 2026—impacted payers, including QHPs on the FFEs,<sup>2</sup> to publicly report certain metrics regarding their prior authorization processes, denials, and utilization. We urge CMS to finalize these new protections related to the use of prior authorization and to clarify that mental health emergencies do not require prior authorization.

In this RFI, CMS asks about plan strategies “to reduce utilization and costs, such as use of prior authorization, step therapy, etc.”<sup>3</sup> Unfortunately, many of these tools are used by plans to reduce or delay utilization of medically necessary services, including through the increase burdens on patients and providers, including our members. Any concomitant decrease in costs is not to be lauded but, in fact, often represents a barrier to accessing services and negatively impacts patient health, outcomes and care. **As CMS works with states, which are generally the primary enforcers of EHB, we urge CMS to ensure that prior authorization and other utilization management tools are not serving as barriers to enrollees in the small and individual markets from accessing essential health benefits.**

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<sup>1</sup> CMS, “Advancing Interoperability and Improving Prior Authorization Processes...,” 87 Fed. Reg. 76,351 (Dec. 13, 2022).

<sup>2</sup> Proposed 45 CFR §156.223(c) in CMS, “Advancing Interoperability and Improving Prior Authorization Processes...,” 87 Fed. Reg. 76,370 (Dec. 13, 2022).

<sup>3</sup> CMS, “Request for Information; Essential Health Benefits,” 87 Fed. Reg. 74,099 (Dec. 2, 2022).

In addition, as consumers consider which plan to enroll in, they should have access to information on the extent to which plans are denying services through prior authorization or other utilization control practices. Regardless of whether those plans operate in an FFE, a state-based exchange, or outside of exchange coverage, consumers should have access to metrics on plans' prior authorization processes, denials, and utilization. Giving consumers a better picture of plan utilization control practices during the enrollment process could go a long way to educating enrollees on the potential access challenges they could face – especially if they have a known medical condition.

Aggressive utilization control practices are a problem that the FAH and other stakeholders have raised with CMS for several years, across many payer types. FAH members have regularly observed that plans abuse prior authorization requirements, maintain inadequate provider networks, use extended observation care, retroactively reclassify patient status (*i.e.*, inpatient versus observation), improperly down code claims, deploy inappropriate pre- and post-payment denial policies, and even deny claims for previously authorized services. All of these activities limit enrollees' access to the care.

### **Addressing Gaps in Coverage and Changes in Evidence and Technology**

Under the current regulatory structure for EHBs, states may select a plan as an EHB benchmark that is from 2017 or before. While this provides stability and consistency, the inflexible nature could restrict states' ability to reflect plan changes due to medical evidence, scientific advancement, and improved capacity and use of technology. CMS should provide a simplified amendment process so that states can update their EHBs to reflect material expansions of benefits in the EHB benchmark plan, including expanded access to telehealth.

The FAH supports permitting the provision of mental health services furnished remotely, including by hospital staff, to beneficiaries in their homes beyond the COVID-19 PHE. FAH member hospitals have extensively provided these services to patients at home during the PHE and believe that mental health services are well-suited for remote delivery via communication technology, while providing important clinical benefits for patients. In addition, patients across the United States suffer from the serious shortage of qualified mental health providers in this country. This compromises the ability of patients to get timely access to care, and sometimes requires patients to travel long distances for necessary services. The delays associated with provider scarcity have significant negative consequences on health. For example, individuals are likely to develop more acute mental illness when they do not receive needed and timely interventions, ultimately leading to increased suffering for patients and their families, as well as higher burdens on the health care system. The use of communications technology offers an opportunity to interrupt a cascade of negative outcomes by ensuring that care is available promptly.

Multiple studies support the need for ongoing flexibility and expanded coverage of telehealth for mental health services. For example, previous epidemics have shown that the impact on mental health and substance use will continue for years to come.<sup>4</sup> Further studies demonstrate that telehealth is particularly effective in mental healthcare delivery.<sup>5</sup>

Other studies have shown that various types of mental health services can be provided effectively via telehealth, including depression screening, follow-up care after hospitalization, behavioral counseling for substance use disorders (SUD), medication management, and psychotherapy for mood disorders.<sup>6</sup> Telehealth has been found to increase retention for SUD treatment, including medication treatment, especially when treatment is not otherwise available or requires lengthy travel.<sup>7</sup> In addition, there is evidence of reduced utilization of higher-cost services associated with providing access to mental healthcare services via telehealth technologies.<sup>8</sup>

The experience of our members in delivering mental healthcare services, including audio-only services, during this pandemic is consistent with these research studies. They have been able to continue providing mental health and addiction treatment services during the pandemic and have experienced significantly reduced missed appointments by patients. Telehealth has enabled patients and family members to access critical services remotely, which has significantly improved access to a level of care that is simply not otherwise available in most communities, especially in rural areas. **The FAH urges CMS to update plan requirements and to collaborate with states to ensure that telehealth continues to remain a viable option for ensuring patients' access to essential health benefits.**

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<sup>4</sup> Hawryluck L, Gold WL, Susan, S: SARS Control and Psychological Effects of Quarantine, Toronto, Canada. *Emerg Infect Dis.* 10;7: 1206–1212 (July 2004); Reardon S: Ebola's mental-health wounds linger in Africa: health-care workers struggle to help people who have been traumatized by the epidemic. *Nature*, 519; 7541:13 (2015); Goldmann E, Galea S: Mental health consequences of disasters. *Ann Rev Public Health*, 35:169–83 (2014). Available online at [https://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-032013-182435?url\\_ver=Z39.88-2003&rfr\\_id=ori%3Arid%3Acrossref.org&rfr\\_dat=cr\\_pub%3Dpubmed](https://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-032013-182435?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed).

<sup>5</sup> Mace S, Boccanelli A, Dormond M: The Use of Telehealth within Behavioral Health Settings: Utilization, Opportunities, and Challenges. Behavioral Health Workforce Research Center, University of Michigan, (March 2018) Available at [https://behavioralhealthworkforce.org/wp-content/uploads/2018/05/Telehealth-Full-Paper\\_5.17.18-clean.pdf](https://behavioralhealthworkforce.org/wp-content/uploads/2018/05/Telehealth-Full-Paper_5.17.18-clean.pdf); Bashshur RL, Shannon GW, Bashshur N, Yellowlees PM: The empirical evidence for telemedicine interventions in mental disorders. *Telemed J E Health*, 22(2): 7-113 (Jan. 2016).

<sup>6</sup> National Quality Forum and AHA Center for Health Innovation: Redesigning Care: a How-To Guide for Hospitals and Health Systems Seeking to Implement, Strengthen and Sustain Telebehavioral Health. (2019). Available at <https://www.aha.org/system/files/media/file/2020/03/Telebehavioral-Health-Guide-FINAL-031919.pdf>.

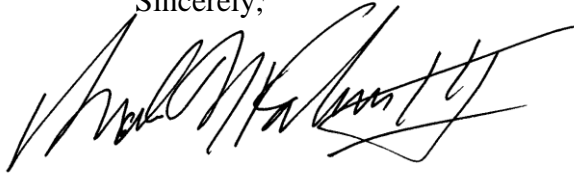
<sup>7</sup> Lin L, Casteel D, Shigekawa E, et al.: Telemedicine-delivered treatment interventions for substance use disorders: A systematic review. *Journal of Substance Abuse Treatment*, 101: 38-49 (June 2019).

<sup>8</sup> Shigekawa E, Fix M, Corbett G, et al. "The current state of telehealth evidence: A rapid review." *Health Affairs*, 37(12): 1975-1982 (2018).

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The FAH appreciates the opportunity to offer these insights. We are committed to working with you to ensure that individuals who are enrolled in plans or coverage that are subject to EHB requirements have improved access to care and greater options for the delivery of that care. If you have any questions or would like to discuss further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,

A handwritten signature in black ink, appearing to be "Andrew R. ...". The signature is fluid and cursive, with a large initial "A" and a long horizontal stroke at the end.