January 30, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue SW
Washington, DC 20201

CMS-9899-P: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024

Dear Administrator Brooks-LaSure:

America’s Essential Hospitals appreciates the opportunity to submit comments on the above-captioned proposed rule related to essential community providers. While we support proposed steps to expand access and simplify marketplace enrollment, we remain concerned that qualified health plan (QHP) networks are not required to include essential hospitals.

America’s Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all. Our more than 300 member hospitals fill a vital role in their communities. They provide a disproportionate share of the nation’s uncompensated care, and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. Essential hospitals provide state-of-the-art, patient-centered care while operating on margins one-third that of other hospitals—3.2 percent on average compared with 7.7 percent for all hospitals nationwide. Essential hospitals’ commitment to serving all people, regardless of income or insurance status, and their complex patient mix pose unique challenges. A disproportionate number of their patients face socioeconomic and sociodemographic challenges to accessing health care, including poverty, homelessness, language barriers, and low health literacy. Seven and a half million people in communities essential hospitals serve have limited access to healthy food, and nearly 16 million live below the poverty line.

Many patients treated by essential hospitals have gained coverage through the Affordable Care Act marketplaces, and many are likely to transition into and out of marketplace coverage over time. Depending on a patient’s employment status, their qualification for employer-based, marketplace, or public insurance might change frequently. It is vitally important, particularly for this under-resourced patient population, that individuals retain continuous access to their

2 Ibid.
providers of choice when their insurance coverage changes. We remain concerned that essential community provider (ECP) threshold requirements and network adequacy standards do not ensure that essential hospitals will be included in QHP networks. This could disrupt existing patient-provider relationships when insurance coverage changes. We ask that **CMS ensure equitable access to QHP beneficiaries’ preferred health care providers through ECP threshold requirements and network adequacy standards.**

Separately, we are pleased to see the proposed rule expand special enrollment periods (SEPs) and simplify several steps in the process to enable individuals to obtain and keep coverage.

1. **CMS must improve ECP threshold standards to ensure that beneficiaries maintain access to their established providers as their eligibility for health coverage changes.**

America’s Essential Hospitals supports the addition of mental health facilities and substance use disorder treatment centers as stand-alone ECP categories. With the increased need for these services and the dearth of providers, requiring their inclusion in a QHP network will increase access for consumers who need them.

However, we remain concerned that ECP threshold requirements do not ensure that essential hospitals are included in QHPs’ networks. Without such a safeguard, essential hospital patients may not be able to retain access to their existing providers and the services they need when their insurance changes between Medicaid and marketplace coverage. As patients’ health insurance changes, participation of essential hospitals in QHP networks is vital for maintaining access to services and ensuring continuity of care.

QHPs currently are required to include 35 percent of available ECPs in-network, but this requirement does not guarantee inclusion of essential hospitals. The current standard only requires QHPs to contract with one provider per category, meaning only one ECP hospital is required to be in-network. Essential hospitals provide high-acuity care, such as level I trauma, burn, and neonatal care. In some cases, they are the only hospital in their community or region to provide these services. Further, essential hospitals provide wraparound services (case management, transportation, nutrition support, legal services, language access, and patient navigation, among others) to meet the needs of their patients facing socioeconomic barriers—the same patients whose eligibility for marketplace coverage is more likely to change over time.

Patients with low incomes should be able to maintain access to their same providers and needed wraparound services as their insurance eligibility changes, including those with incomes at or near Medicaid eligibility levels. Finding new providers because of a change in insurance disrupts care continuity. Continuity of care leads to better health outcomes and is associated with decreased emergency department use and hospitalizations, lower costs, and higher patient satisfaction, as well as lower mortality rates.3-4 To **ensure equitable access to beneficiaries’ established providers, CMS must employ ECP threshold standards that include essential hospitals by requiring that all willing ECPs be in-network for QHPs.**

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2. CMS should require all marketplaces to implement the new SEP for loss of Medicaid and CHIP.

America’s Essential Hospitals supports the new SEP for loss of Medicaid and CHIP coverage. The SEP would align with Medicaid’s 90-day reconsideration window and allows beneficiaries 90 days either to submit the necessary documentation to stay enrolled in Medicaid or CHIP, or to enroll in marketplace coverage. This SEP extension from 60 to 90 days would minimize gaps in coverage for Medicaid beneficiaries who become ineligible and need to find coverage in the marketplace. The SEP alignment with Medicaid’s 90-day reconsideration period will be particularly important for consumers when states restart Medicaid redeterminations after their pause during the COVID-19 public health emergency. Eighteen million people are expected to lose Medicaid coverage. An estimated one million are expected to transfer to marketplace, and an additional 1.5 million will be eligible for marketplace coverage but will not enroll.\(^5\) This SEP will provide these consumers a longer grace period to enroll in needed health coverage on the marketplace. We urge CMS to mandate that all marketplaces implement this expanded SEP.

3. CMS should finalize changes that simplify the marketplace enrollment process.

The association supports several proposed changes that simplify selecting, enrolling in, and keeping health coverage on the marketplaces. Many patients of essential hospitals have low health and health care literacy, and selecting and enrolling in a plan can be confusing and overwhelming, even when patients receive assistance. The proposed changes to make the enrollment process easier and more understandable will benefit essential hospital patients and other consumers enrolling in marketplace coverage.

a. CMS should ensure marketplace plans are meaningfully different.

Reducing the number of plan options on the marketplace while maintaining meaningful and affordable plan options will help consumers make an informed choice about their health care coverage. Either limiting the number of nonstandardized plans by issuers or applying a meaningful difference standard based on deductibles would simplify options for consumers, clarifying what each plan covers, differences among the plans, and the out-of-pocket costs for each plan. Establishing marketing requirements that streamline plan names also would be helpful in the selection process. CMS should simplify plan options on the marketplace so consumers can make an informed decision about their health plan.

b. CMS should allow navigators and assisters to enroll consumers during door-to-door outreach.

We are pleased navigators and assisters will be able to enroll consumers during door-to-door outreach and education efforts. Doing so will make outreach efforts more efficient and convenient for consumers. However, we ask CMS to ensure navigators and assisters

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have the proper equipment and broadband so that the enrollment process is not burdensome.

We encourage CMS to ensure support for navigators and assisters conducting door-to-door outreach for potential consumers whose first language is not English. In the same vein, CMS should consider what support might be needed during outreach for consumers who need audio or visual auxiliary services. **CMS should ensure all potential consumers have access to enrollment services during door-to-door outreach.**

c. **CMS should clarify the reenrollment hierarchy when consumers lose cost-sharing reduction eligibility.**

Finally, we support the proposed change to the automatic reenrollment hierarchy. This hierarchy automatically would reenroll consumers eligible for cost-sharing reductions (CSRs) with bronze level plans into silver level plans, providing consumers will similar coverage and lower out-of-pocket costs. However, the proposed rule is unclear regarding which metal level an individual would be reenrolled into in the following year should the consumer lose eligibility for CSRs. **CMS should clarify the reenrollment hierarchy for consumers who were enrolled in a silver plan with CSRs but become ineligible for CSRs the following year and are due to be reenrolled in a marketplace plan.**

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The association appreciates the opportunity to submit these comments and looks forward to additional opportunities to work with CMS to advance access to care. If you have questions, please contact Erin O’Malley, senior director of policy, at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO