October 31, 2011

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS -9989-P
P.O. Box 8010
Baltimore, MD 21244-8010

The National Association of Community Health Centers, Inc. (NACHC) is pleased to respond to the above-cited request for comments from the Department of Health and Human Services (HHS). NACHC is the national membership organization for federally qualified health centers (hereinafter interchangeably referred to as "health centers" or "FQHCs") throughout the country, and is a Section 501(c)(3) tax-exempt organization.

NACHC is limiting its comments primarily to issues that are of particular importance to health centers in their efforts to play a critical and supportive role in the implementation of health care coverage expansion and reform as provided in the Patient Protection and Affordable Care Act (ACA), Pub. L No. 111-148, enacted on March 23, 2010. In this regard, we also have attached, incorporate and (where, we believe, particularly relevant to our comments herein) reiterate the comments we submitted to HHS on October 4, 2010 in response to its earlier request for comments (75 Fed. Reg. 45584 et seq, Aug. 3, 2110) regarding the Exchange Related Provisions in the ACA.

I. Background

To best explain and support our focus on certain Exchange implementation and enforcement policies, we believe the following background review is appropriate.

There are, at present, more than 1200 health centers with more than 8000 sites serving more than 20 million patients nationwide. Most of these health centers receive federal grants under Section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) from the Bureau of Primary Health Care (BPHC), within the Health Resources and Services Administration (HRSA) of HHS. Under this authority, health centers fall into four general categories: (1) those centers serving medically underserved areas, (2) those serving homeless populations within a particular community or geographic area, (3) those serving migrant or seasonal farmworker populations within similar community or geographic areas, and (4) those serving residents of public housing.

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To qualify as a Section 330 grantee, a health center must be serving a designated medically underserved area or a medically underserved population. In addition, a health center's board of directors must be made up of at least fifty-one percent (51%) users of the health center and the health center must offer services to all persons in its area, regardless of one's ability to pay. BPHC's grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing comprehensive preventive and primary care and enabling services (such as translation, transportation services, smoking cessation classes, etc) to uninsured and underinsured indigent patients, as well as to maintain the health center's infrastructure. Patients from eligible communities, who are not indigent and are able to pay or who have insurance, whether public or private, are expected to pay for the services rendered. Approximately 39 percent of health center patients are Medicaid recipients, approximately 7.5 percent are Medicare beneficiaries, and approximately 38 percent are uninsured. NACHC estimates that the Medicaid expansions mandated in the ACA will result in health centers serving approximately 18.4 million Medicaid recipients by 2015.

Congressional support and funding for health center services and expansion has been bipartisan and unequivocal, particularly in the past twenty years. Evidence of this support is as follows:

1. Recognizing the importance of health center services to Medicaid beneficiaries, Congress in the Omnibus Budget Reconciliation Act of 1989 made the services of a Federally Qualified Health Center (FQHC) a guaranteed Medicaid benefit offered to beneficiaries in every State Medicaid program. Most important, Congress recognized and acknowledged that Medicaid reimbursement to FQHCs must be sufficient to assure that health centers were paid their full reasonable costs for serving Medicaid patients (to ensure that they would not have to use their Public Health Service Act grant funds to subsidize low Medicaid payments). In the accompanying Committee report, lawmakers wrote:

   > *The Subcommittee on Health and the Environment heard testimony that, on average, Medicaid payments to Federally-qualified health centers cover less than 70 percent of the costs incurred by the centers in serving Medicaid patients. The role of [the federal Health Centers program] is to deliver comprehensive primary care services to underserved populations or areas without regard to ability to pay. To the extent that the Medicaid program is not covering the cost of treating its own beneficiaries, it is compromising the ability of the centers to meet the primary care needs of those without any public or private coverage whatsoever.*
   > U.S. Congress, House Rpt Committee Print 101-M, p.63 (1989).

   Congress further amended Medicaid payment methodology in 2000, to assure that health centers receive a payment that approximates their costs in serving their Medicaid patients. 42 USC 1396a(bb). This Medicaid FQHC Prospective Payment System (PPS) mandate is almost unique in the Medicaid statute, as Congress is inclined generally to

allow states a great deal of leeway in establishing provider payment. However, as explained in the legislative history cited above, this FQHC payment requirement reflects Congressional recognition of the importance of FQHCs' provision of primary care and preventive services to the poor in this county.

2. In 1990, Congress, for reasons similar to its 1989 Medicaid enactment, created a similar payment methodology for FQHCs in the Medicare program. In the ACA, Congress amended this payment requirement, effective 2014, and provided that unreasonable payment caps and screens are not to be applied in any Medicare payment system that CMS may implement for FQHCs in 2014. Section 10501(i)(2) of ACA.

   Since the enactment of these Medicaid and Medicare FQHC provisions, both government and taxpayers have benefited through optimum use of the federal Health Center grant funds to care for more uninsured and under-insured individuals because these specific Medicaid and Medicare FQHC payment requirements have been in place.

3. Significantly, in 2009, Congress—in reauthorizing and expanding the CHIP program—required that CMS reimburse FQHCs for services to CHIP beneficiaries no less than what the center would receive for such services under the Medicaid FQHC PPS system, once again assuring that FQHCs are reimbursed their costs in serving their low-income patients. 42 USC 1397gg(e)(1)(E).

4. Between 2000 and 2008, Congress increased health center grant funding to allow for the doubling of the number of health centers during that eight year period.

5. In the American Recovery and Reinvestment Act of 2009 (ARRA), Pub L No 111-5, Congress appropriated $500 million in Section 330 grant funds for health center expansion (over and above their $2.1 billion annual appropriation) and provided an additional $1.5 billion for health center capital/infrastructure and HIT costs. In that same legislation, Congress also provided funding incentives in the Medicaid (and Medicare) program for providers who could demonstrate meaningful use of certified electronic health records (EHR) technology. Section 4201 of ARRA. Notably, in that legislation, FQHCs are the only non-hospital entity for which Congress established multiple provider eligibility and payments when such providers practice predominantly at FQHCs.

6. Finally, in the ACA, Congress established a Community Health Center Trust Fund that provides $9.5 billion for health center capacity and service expansion operations over a five year period beginning in 2011 and an additional $1.5 billion for health center capital projects. In effect, Congress has signaled and funded health centers to be at the forefront of the expansion and provision of primary care to the many previously

uninsured individuals and families who will be covered in 2014 through ACA's Medicaid expansion and Exchange and Qualified Health Plan mandates.

Throughout this 20 year period of health center expansion, and to a great degree the rationale for this expansion, has been the bipartisan recognition by Congress, by Administrations, in various academic studies, etc., that health centers provide critical cost-effective and cost-efficient primary and preventive health care and enabling services to a relatively high-risk vulnerable population and that they offer a health care home model that should be a central and necessary component in any legislative effort and subsequent public policy seeking to expand coverage to the uninsured and under-insured in this country.[1] It is in this context, that NACHC believes that its comments in the following section of this document require close and careful consideration by HHS.

II. FQHC Participation in the ACA Exchange

A. The ACA's Requirements Regarding QHPs Contracting with Essential Community Providers (ECPs), Payment to FQHCs, and Assuring Sufficient Access to QHPs

The ACA includes several specific requirements that relate directly to FQHC participation in QHPs that seek to participate in state or federally operated Exchanges. First, Section 1311(c)(1) provides that Exchanges :

> shall require that to be certified a plan shall, at a minimum—
>
> *** *** ***
>
> (C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act…..
> Section 1311(c)(1)(C) of ACA.

Thus, Section 1311 of the ACA requires the Secretary to ensure, by regulation, that Exchanges only certify plans that include "essential community providers" that serve "predominantly low-income medically underserved individuals." These terms essentially define FQHCs and, as noted by CMS, FQHCs are specifically listed as a covered entity in Section 340B(a)(4).

As noted in the preamble to the proposed rule, Section 1311(c)(2) provides that a qualified health plan(QHP) need not contract with an essential community provider (ECP) who refuses to accept the

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[1] During this key period, Congress has underlined its support for the unique role of health centers through additional legislative initiatives. In 1992, Congress passed legislation, which was amended and improved in 1995, that allows health center grantees, their employees and certain contractors, to be covered under the Federal Tort Claims Act, thereby saving health centers millions of dollars in malpractice insurance expenditures, and these savings are now used by centers for service expansion and to reach additional patients. 42 USC 233(g)-(m). Also in 1992, Congress passed legislation that required drug manufacturers seeking to provide and be reimbursed for prescription drugs for Medicaid patients, to provide states with rebates for such drug costs and to provide discounts (comparable to the rebate received by the states) for drugs purchased by FQHCs and certain other enumerated "covered entities." Section 340B of the Public Health Service Act; 42 USC 256. This drug discount program—referred to as the "Section 340B program"—has saved health centers millions of dollars in prescription drug costs, and those savings have been used by centers to further expand services and patients served.

"generally applicable rates of such a plan." However, Section 10104 of that Act "amended" Section 1302 by adding a new paragraph (g) which states:

> If any item or service covered by a qualified health plan is provided by a Federally-qualified health center as defined in [the Medicaid section of the] Social Security Act to an enrollee of the plan, the offeror of the plan **shall pay** to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under Section 1902(bb) of such Act (emphasis added).

In the preamble, CMS suggests that Section 1311 and the amended Section 1302 quoted above "may conflict" and suggests two potential approaches, neither of which, we believe, would result in an interpretation of the ACA that gives effect to all of its provisions (one approach is to use a health center's specific Medicaid PPS rate as a floor and the other is to ignore it altogether). The problem with the first approach, according to the preamble, is that a center's Medicaid PPS rate may be higher than the rate a QHP may be willing to pay and, accordingly, a QHP may decide not to contract with a health center. The problem with the second approach is that it simply ignores Section 1302(g). We believe there is another interpretation, which is to interpret Section 1302(g) as requiring a methodology, not a specific payment rate, that will give effect to all of the provisions of the ACA, be consistent with Congressional intent and past CMS guidance. Such an interpretation is not only possible but required by long-standing federal law.

As an initial matter, canons of statutory construction require that CMS make every effort to read the two statutory provisions harmoniously and to give effect to both provisions to the greatest extent allowable. *J.E.M. Ag Supply, Inc. v. Pioneer Hi-Bred Intern., Inc.*, 534 U.S. 124, 143-44, 122 S.Ct. 593, 605 (2001), quoting *Morton v. Mancari*, 417 U.S. 535, 551, 94 S.Ct. 2474 (1974). These canons also make clear that statutory analysis starts with the plain language of the statute but, to the extent the language is ambiguous or appears to be in conflict, CMS should turn to the legislative history of the potentially conflicting provisions. *Watt v. Alaska*, 451 U.S. 259, 266, 101 S.Ct. 1673, 1678 (1981) ("Without depreciating this general rule [that the more recent of two conflicting statutes governs], we decline to read the statutes as being in irreconcilable conflict without seeking to ascertain the actual intent of Congress."). "Congress may amend a statute to establish new law, but it also may enact an amendment 'to clarify existing law, to correct a misinterpretation, or to overrule wrongly decided cases.'" *Brown v. Thompson*, 374 F.3d 253, 259 (4th Cir. 2004), quoting *United States v. Sepulveda*, 115 F.3d 882, 885 n. 5 (11th Cir.1997). In addition, Congress is presumed to have knowledge of the laws and regulations already in existence when it passes a new law. *Cannon v. University of Chicago*, 441 U.S. 677, 696-97, 99 S.Ct. 1946, 1957-58 (1979) ("It is always appropriate to assume that our elected representatives, like other citizens, know the law").

Taking these well-settled legal principles and using them to analyze the interaction of Sections 1302 and 1311, the fact that Subsection(g) of Section 1302 was added to Section 1302 through a separate and subsequent section of the ACA—Section 10104— is a critical fact that was not addressed in the preamble (*see e.g.*, p. 41899). As Congress is presumed to have complete knowledge of the law, simple

logic would dictate that a conflict between Sections 1302 and 1311 is not possible. CMS must either read the two sections harmoniously or read the latter provision, Section 1302(g) as added by section 10104, to implicitly repeal any conflicting provision of the earlier Section 1311. We believe, however, that a harmonious reading, particularly when viewed in the light of over twenty years of Congressional action concerning funding for health centers, is possible and warranted in this instance.
Simply put, we do not believe that the "not less than" language means, as stated by CMS in the preamble, that a QHP must "reimburse FQHCs at each facility's Medicaid prospective payment system (PPS) rate" but rather that QHP must utilize the methodology established under 1902(bb) of the SSA to pay health centers no less than the amounts paid under Medicaid **for the items or services provided by the FQHC to patients of the QHP.** That is, a QHP must pay a health center at least its reasonable cost of providing covered services (not Medicaid services) using two base years to determine a per visit rate that would then be adjusted for inflation and changes in the scope of services provided. Importantly, Section 1902(bb) also provides the two contracting parties, QHPs and health centers, considerable flexibility to enter into payment terms that may be more workable or advantageous for any number of reasons through the alternative payment methodology provisions found in subsection (6) of 1902(bb). This approach is actually the only reasonable way to read Section 1302(g) as there is no reason why Congress would have intended a QHP to be paying an FQHC for a Medicaid bundle of services that might be different than the bundle of services that the FQHC is furnishing to an enrollee of a QHP.

Adopting this approach is wholly consistent with the concept that health centers must use their Section 330 funds solely for serving low-income uninsured populations. As Congress has made clear, the purpose of the PPS rate and predecessor provisions is to ensure that Medicaid pays for the cost of serving Medicaid enrollees. It is not a rate paid just for a "visit," but a method of fairly allocating the cost of services provided to individuals covered by different payors (Section 330, Medicaid and Medicare).[2]

With respect to the Exchanges and QHPs, CMS states in the preamble to the proposed rule that there is no reason to assume that the item or services provided by a QHP will be the same as those provided in a particular state under that state's Medicaid program. That may or may not be the case depending on CMS's forthcoming proposed rules on the Essential Health Benefits that must be made available to Exchange enrollees. If these services are the same as those covered by Medicaid and provided by an FQHC to its Medicaid patients, then the payment owed to the FQHC for the Exchange enrollee may well be the same as the payment it would receive under its Medicaid PPS per visit rate. If the services are

[2] While the PPS payment methodology may be unusual in managed care, it seems unlikely that, if a plan considers all the services that a health center provides, the cost of those services will be higher than any other provider group and likely to be lower. A health center's costs are closely scrutinized by HRSA, CMS and many if not most State Medicaid agencies. There is no evidence that these costs are above the norm and, to the contrary, study after study has shown that health centers are cost effective providers of primary care services. A comprehensive list of studies and reports can be found at:
http://www.nachc.com/client/documents/HC%20Quality%20Studies%2004.11.pdf
http://www.nachc.com/client/documents/HC%20Cost%20Effectiveness%20Studies%2002.11.pdf
http://www.nachc.com/client/documents/HC%20Disparities%20Studies%2004.112.pdf
http://www.nachc.com/client/documents/HC%20access%20to%20care%20studies%2004.11.pdf

not the same, we would expect that the PPS rate for a QHP would not necessarily be the same as the PPS rate paid by a state Medicaid program but that the health center is paid a sufficient amount to approximately cover its costs on a per visit basis as provided for in Section 1902(bb).

Given this requirement in the amendment to Section 1302 of the ACA that FQHCs be paid no less than what they would be paid under the Medicaid payment methodology in 1902(bb), it seems clear that 1311(c)(2) cannot be read to allow a QHP to not contract with a health center that seeks to be paid on that basis. Otherwise, the ACA would have to be read to require plans to contract with ECPs such as FQHCs unless the FQHC seeks to be paid what the ACA requires it be paid. Congress could not have intended such a contradictory result. Once again, the aforementioned canons of statutory construction require that CMS make every effort to read two statutory provisions harmoniously and to give effect to both provisions to the greatest extent allowable. Complying with these principles of statutory construction is not difficult in this instance. The appropriate reading of these provisions would be that FQHCs, as ECPs, should be contracted by plans and paid **no less** than what they would receive for their services under Medicaid PPS reimbursement methodology. Put another way, HHS could reconcile these provisions as meaning that the “generally applicable rates of such a plan” (as provided in 1311(c)(2)) for services furnished by an FQHC is an amount no less than the amount that would be paid to FQHC’s under the 1902(bb) per visit payment methodology.

The propriety of this approach is strengthened when another requirement of the ACA is factored in. Section 1311(c)(1)(B) requires that HHS regulations ensure sufficient choice of providers, and HHS appropriately reads this provision in concert with the ECP provision “to require that QHP issuers include a sufficient number of ECPs where available to serve low income medically underserved individuals” 76 Fed Reg, at 41899. There are more than 8000 FQHC sites serving MUAs and/or serving MUPs throughout the United States. They are providing preventive and primary care services to more than 20 million patients most of whom are low-income uninsured or Medicaid recipients. Given the increased funding for FQHCs in the ACA and the implementation of Exchange/QHP coverage in 2014, FQHCs are expected to be serving millions of additional patients by 2015, many of whom will be eligible to enroll in, and receive tax subsidies to support their enrollment in, Exchange QHPs. In short, FQHCs provide HHS, the Exchanges, and QHPs an avenue for assuring compliance with the “sufficient choice of providers in medically underserved areas” requirements of the ACA.

B. Meeting the ACA Requirements through “Any Willing FQHC” and “No Less Than Medicaid PPS Payment” Regulations

A straight forward approach through which HHS can reconcile the FQHC payment and ECP contracting provisions of the ACA and, at the same time, take a major step toward meeting the adequate choice of providers (for those living in MUAs/MUPs) instruction in the ACA, would be:

1. To draft the network adequacy and ECP contracting rules (42 CFR 155.1050, 156.230, and 156.235) and rules related to these rules—such as QHP plan accreditation (42 CFR 156.275)--to require Exchanges to require QHPs that seek to participate in Exchanges to contract with any

FQHC in the QHP service area for all services offered by the FQHC that the QHP is obligated to provide to its enrollees under the requirements of the Exchange; and

2. To further provide in 42 CFR 156.235, that payment to FQHCs for such services be no less than the FQHC would be reimbursed for such services applying the payment methodology under Section 1902(bb) of the SSA.

NACHC's proposal that, in essence, the final rule require QHPs to contract with "any willing FQHC" is a narrower mandate than the "any willing ECP" proposal that CMS is reluctant to adopt. It limits required contracting to a particular subset of ECPs that are at the forefront of the delivery of cost effective primary care and preventive services and operate as patient centered medical homes. Moreover, FQHCs are required to meet stringent reporting, quality and financial accountability standards under Section 330 of the PHS Act and regulations and policies promulgated there under by BPHC/HRSA. Consequently, required contracting with FQHCs would limit the contracting mandate to closely monitored, closely regulated, proven providers of high quality cost efficient primary care services in 8000 sites located in MUAs/MUPs, and would not at all limit the opportunity for QHPs to contract with other ECPs as well.

An additional reason for CMS's mandating QHP's contracting with "any willing FQHC" is that such a rule will substantially alleviate the payment issues QHPs would have to contend with when their enrollees go out of plan to be treated by an FQHC. Section 1302(g) of the ACA provides that "[i]f any item or service covered by a qualified health plan is provided by a Federally-qualified health center as defined in [the Medicaid section of the] Social Security Act to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under Section 1902(bb) of such Act." This provision does not limit QHP payment to an FQHC that is a contractor with the plan and would therefore require such payment to the center for services provided to a QHP enrollee who has gone out of plan to be treated by the FQHC. By contracting with such FQHCs, the QHP will have a process and payment system already in place for appropriate payment to the FQHC per the requirements of Section 1302(g).

In the preamble to its proposed rules, CMS indicates that it is reluctant to require QHPs to pay the equivalent of the Medicaid FQHC PPS rate to FQHCs because "if FQHC Medicaid PPS rates are greater than the comparable amounts paid to other providers , and if many of the enrollees in a QHP receive care at the FQHC, the costs of these QHPs may be greater than the cost of QHPs that do not have many enrollees that are seen at the center" and also "these higher costs could lead to insurers to minimally contract with FQHCs." 76 Fed. Reg., at 41899. NACHC appreciates and shares this concern, but we believe that there are specific rules that CMS could require that Exchanges and QHPs adopt that would minimize, and possibly eliminate, such disincentives to contract and enroll patients with FQHCs.

One approach would be for QHPs to be required to pay FQHCs no less than what they would pay other providers for comparable services, that is, as CMS states in its preamble the issuers could negotiate payment with FQHC "as long as they are at least equal to the issuer's generally applicable payment rates." 76 Fed Reg. at 41900. However, the FQHC would also be paid by the Exchange or the QHP (or another source) the difference between the payment it received from the issuers and the amount it

would receive under the Medicaid reimbursement methodology provided for in 1902(bb). This approach would basically reflect the so-called "wrap-around" payment methodology provided to FQHCs in the FQHC Medicaid provisions in Section 1902(bb) of the Social Security Act, which, of course, is exactly what is called for in Section 1302(g) of the ACA.

The source of the wrap-around payment is the obvious concern but there appear to be a number of ways that these funds can be found. For example, HHS' regulations could require that assessment fees be paid by all insurers offering plans in the state (42 CFR 155.160 and 156.50) that include specific amounts that could be used to pay wrap-around payments by the Exchange to participating FQHCs, much like a state makes such wrap around payments today in the Medicaid program. We suggest that this assessment or user fee not be limited to plans in the Exchange but apply to all issuers offering plans in the state (in and/or outside of the Exchange) so as to assure a level playing field and not undermine the viability of the Exchange.

Alternatively, HHS could revise its proposed rules relating to reinsurance, risk corridors and risk adjustment (76 Fed Reg 41930 et seq. (July 15, 2011)) to require factoring in the additional risks and costs that are likely to be incurred by QHPs that are contracting with FQHCs so that these plans are assured that the calculations of such risk programs will be constructed to account for "wrap around" payments—thereby leveling the playing field for the plans with greater numbers of enrollees that are being served by FQHCs.[3] Certain additional factors could be built into these risk calculations such as the fact that FQHCs are usually serving a population that is low income and has a higher health risk than those served by other plan providers and that also require additional provider costs relating to transportation, translation services, and other culturally appropriate considerations in treating these populations. In short, risk adjustment systems could factor in the number of patients being served by FQHCs that are contracting with a QHP, and adjust the QHP risk accordingly. They might even factor in the patient centered health care home approach to care that is the hallmark of FQHCs and therefore allow for higher costs at the front end but build in gradually lower costs in the out years to reflect the fact that, as a result of FQHCs providing services to its enrollees, the QHP will likely be paying less for hospital admissions, hospital readmissions, emergency room treatments and costs related to chronic disease.

C. NACHC's "Any Willing FQHC" and "No Less Than Medicaid PPS Payment" Proposal Advance Other Provisions of the ACA and Are Consistent with Prior Congressional Actions

Strengthening the rationale and legal basis for HHS to require that Exchanges require QHPs to contract with any willing FQHC is that such a mandate advances other provisions and goals in the Exchange law. For example, CMS states in the preamble discussion relating to establishment of Exchange network adequacy standards (Section 155.1050) that it recognizes that "primary care access is a challenge in

[3] NACHC is not submitting separate comments in response to the above-referenced reinsurance/risk corridor/risk adjustment proposed rules, but requests that our comment and proposal that HHS revise those proposed rules to provide for risk adjustment systems reflecting QHP contracting with FQHCs also be treated as a formal comment in response to those proposed rules.

many communities nationally, and that more consumers may seek routine primary care services in 2014 given improved access to health insurance coverage" 76 Fed Reg., at 41894.

The agency then states:

> Consistent with the goals and policies of the Affordable Care Act in supporting primary care, in establishing provider networks that ensure broad access to care we encourage States, Exchanges and health insurance issuers to consider broadly defining the types of providers that furnish primary care services (e.g. nurse practitioners).
> 76 Fed Reg, at 41894

FQHCs are the only 340B covered entity/ECP whose major focus is the delivery of **primary care** and who are located in the more than 8,000 sites serving MUAs/MUPs. FQHCs employ or contract with more than 3,808 nurse practitioners, 2,034 physician assistants, and 1,265 licensed social workers. In short, by requiring QHPs to contract with any willing FQHC, CMS would be taking major strides in attaining the goals of the ACA as so well articulated by CMS: assuring the availability of a broad network of physicians and mid-level providers located in MUA and serving MUPs, whose focus is on the delivery of primary and preventive care services.

In addition, NACHC's proposed regulatory application of these provisions of the ACA (contracting with ECPs, PPS payment to FQHCs, and sufficient access to primary care providers in medically underserved areas) is the only such reading that is consistent with the direction of Congressional legislative support of health centers over the past twenty years as itemized in the earlier section of our comments. It is inconceivable that Congress would consistently support the growth of health centers over the past twenty years—provide them payment in Medicaid and CHIP that must approximate their costs, provide them malpractice protection and discounted prescription drugs, double their numbers over an eight year period, enhance their accessibility to EHR, increase their funding for health center construction by $1.5 billion in the American Recovery and Reinvestment Act (PL 111-5), and in the ACA entrust them with a five year multi-billion dollar Fund to substantially increase the number of patients they will serve and then, in that very same ACA, intend to have these provisions applied in a way that would require plans to contract with only those FQHCs that do not insist on a payment methodology that the same Act requires plans pay them (and is comparable to what they are paid in Medicaid and CHIP).

For the reasons provided above, NACHC believes that final HHS Exchange regulations must make clear that Exchanges can only certify plans as Qualified Health Plans (QHP) if those plans are contracting with any willing FQHC and reimbursing that FQHC for the services it is providing to plan enrollees at no less than it would be reimbursed for those services under the Medicaid FQHC reimbursement methodology provided for in Section 1902(bb) of the SSA.

III. Other CMS Proposed Exchange Regulations

HHS Operation of an Exchange (42 CFR 155.105(f)): CMS should provide more detail in its final rule, and in the preamble to that rule, regarding the operations and requirements of a federally facilitated Exchange, if and how federally operated exchanges might differ from state to state, etc. Particularly important, the final rule should make clear that the regulatory provisions relating to contracting and payment of FQHCs that NACHC maintains (in the previous section of our comments) are legally and practically appropriate to the state-run Exchanges would also apply to federally operated Exchanges.

Contracting Exchange functions to Outside Contractors (42 CFR 155.110(b)): Certain functions and responsibilities of an Exchange should not be eligible for contracting to non-governmental entities, including the following:

- Establishing standards for qualified health plans offered in the Exchange (and ensuring these standards are consistent with section 1557 of the Act);
- Negotiating with or selecting plans to participate in the Exchange;
- Certifying and decertifying plans to be offered in the Exchange;
- Regulating the practices of insurance plans in the Exchange including monitoring marketing practices, ensuring that benefits are not designed to cherry pick healthier enrollees, ensuring adequate choice of providers, and monitoring the handling of consumer complaints;
- Administering risk adjustment mechanisms among participating insurers;
- Determining whether individuals qualify for the federal premium tax credit and the cost-sharing reductions and if they do not, screening and enrolling them for eligibility for public programs like Medicaid;
- Establishing policies and procedures for verification of Social Security numbers, tax credit eligibility and immigration status with federal agencies;
- Resolving inconsistencies with information as reported by the Social Security Administration, Department of the Treasury or Department of Homeland Security;
- Handling and transmitting a variety of confidential information including federal income tax return data, income and other information included in Medicaid applications, and Social Security Administration data;
- Establishing eligibility criteria, selecting and overseeing the Navigator program; and
- Assessing fees to participating health insurers or to otherwise fund the ongoing operation of the Exchange.

Stakeholder Consultation (42 CFR 155.130): Our recommendations on this proposed rule are that: (1) there be a clear requirement that safety net providers be included among stakeholders to be consulted; (2) to avoid conflicts of interest, health insurance issuers, agents and brokers who are consulted as stakeholders be limited to those issuers that offer QHPs and to those agents and brokers that enroll individuals or employees/employers in an Exchange; and (3) Navigators be added to the list of stakeholders with whom Exchanges must consult.

Composition of an Exchange Board of Directors (42 CFR 155.110(c)): An Exchange Governing Board should have at least a majority of its board members comprised of "consumer representatives" and

that term should be defined to include a customer of an Exchange plan or a representative of a non-profit organization that serves or advocates for constituencies served by the Exchanges.

Membership on the Exchange should include at least one individual representing safety net providers—such as the State Primary Care Association—that have been providing services to low-income uninsured individuals and families who are likely to be enrollees in QHPs that are certified by the Exchanges. Representation on the Board by safety net providers (as well as by consumer organizations representing low-income individuals) is important because they will be familiar with the issues of coordination of various coverage programs and systems such as Medicaid and CHIP. They will also be familiar with issues relating to language barriers, cultural competency, transportation and related barriers to access.

Members of an Exchange Plan should not have a conflict of interest and thus should not include insurers or those affiliated with the insurance industry or a related trade association or an entity that would contract directly with the Exchanges such as QHPs or MCOs or a related group. To the extent that the final rule allows members on the Exchange that have a conflict of interest, those members should be required to recuse themselves from any discussion and vote on a topic in which they have such a conflict.

Outreach and Education (42 CFR 155.205(e)): This rule should be more specific on the minimum requirements of an Exchange related to outreach and education. It should underline that outreach and education should focus on contacting underserved populations, particularly hard-to-reach populations and those that experience health disparities due to low literacy, race, color, national origin or disability including mental illnesses and substance abuse disorders. It should also require coordination among various entities, including Navigators, and should require that information conveyed is accurate, appropriate and fair.

NACHC also believes that the success of Exchange outreach and education activities will be substantially enhanced if they build on, and are coordinated with, similar activities that are already being carried out with regard to Medicaid and CHIP enrollment and eligibility. Consequently, we ask that the final rule and its preamble take note of currently existing outreach and educations activities in the Medicaid and CHIP programs--such as the outreach grants provided to state agencies, community health centers and other entities per CHIPRA of 2009--and stress the importance of Exchange coordination with those activities. In this regard, we also ask that the final rule and preamble note the requirement in the Medicaid statute calling for outstationing of eligibility workers at FQHCs (Section 1902(a)(55) of the Social Security Act) and build on this provision by requiring Exchanges to assure that FQHCs are able to participate in Exchange outreach and education activities .

Navigator Program (42 CFR 155.210):

155.210(a): The Exchange should be required to conduct a needs assessment of individuals and small businesses to be served through the Exchanges to determine the number and types of entities to be selected as Navigators, with particular emphasis on assuring that the Navigator program will be able to adequately assist those living in MUAs/MUPs. In these areas, preferred consideration should be given to awarding Navigator grants to State Primary Care Associations and other associations whose membership are comprised primarily of safety net providers.

The Exchange should establish a Navigator training curriculum and certification requirements, and set quality standards and develop mechanisms to assess Navigator performance and accountability in meeting these standards.

No less than two types of qualified entities should be selected by the Exchange to serve as Navigators and one of those entities should be a community or consumer-oriented non-profit organization.

155.210(b): Navigators should not be subject to state or other licensure requirements.

155.210(c): Navigators should not be able to serve as active health insurance producers or agents in any health insurance market and should not receive any direct or indirect consideration from any health insurance issuers inside or outside of the Exchanges during their term as Navigator. This prohibition should apply to the Navigator receiving grants or gifts directly or indirectly from an insurer

155.210(d): Navigator's duties should include assisting consumers in applying for premium tax credits and cost-sharing reductions. Navigators should be subject to specific requirements regarding translating materials and providing oral assistance through competent interpreters or bilingual staff to Limited English speaking individuals.

Agents and Brokers (42 CFR 155.220): States electing to allow agents and brokers to enroll individuals in an Exchange should be required to develop rules and monitoring systems to minimize adverse selection and to prohibit steering enrollees to particular plans for financial reasons unrelated to the consumer's best interests.

Enrollment, Effective Dates of Coverage and Special Enrollment (42 CFR 155.405, .410 and.420):

155.405: Paragraphs (a) and (b) should state that applicants can only be required to provide the minimum information necessary to complete an eligibility determination, and subparagraph (c)(2) should retain clause (iv) which requires that an individual be allowed to file the application in person.

155.410(b): Since so many people seeking assistance and securing coverage in these new systems will need to understand and consider their options and then will have to complete an eligibility and

enrollment process, the initial enrollment period should be expanded to begin October 1, 2013 through March 31, 2014.

155.410(c): An applicant should be allowed to choose an effective date of coverage starting with the date of application or on the first day of an upcoming month.

155.410(e): the annual open enrollment period should be extended to run from October 15 through December 15.

155.420: The effective start date of coverage during a special enrollment period should reflect the circumstances of the triggering event so as to avoid coverage gaps. Also, pregnancy should be included as a qualifying event for special enrollment.

Exchange Network Adequacy Standard (42 CFR 155.1050 and 156.230): For the reasons provided in our discussion in the previous section of these comments, NACHC believes that requiring each QHP to contract with (and to confirm that it is contracting with) "any willing FQHC" serving the QHP's service area should be a critical criterion for a QHP to demonstrate—for purposes of QHP certification and recertification in the Exchange--that it offers a sufficient choice of primary care providers. Also, as already noted, adoption of such a rule and policy would be consistent with, and would be a key element in implementing and enforcing HHS's proposed requirement that Exchanges ensure that "QHPs' provider networks provide sufficient access to care for **all** enrollees, including those in medically underserved areas." (76 Fed. Reg., at 41894).

Recertification of QHPs (42 CFR 155.1075): The final rule should require that an Exchange engage in an active recertification process with a formal annual review of all QHPs. That review should include, among other things, verification of the network adequacy of the plan and that the QHPs are contracting with essential community providers (including "any willing FQHC" as proposed in the previous section of our comments).

Network Adequacy Standards-Notice to Applicants and Enrollees (42 CFR 156.230(b)): We agree that QHPs should be required to make their health plan directory available to the Exchange electronically and to potential and current enrollees in hard copy upon request. In order to assure that enrollees can easily identify whether their current provider or the provider they prefer is in a QHP network, the directory should identify the individual provider by name as well as the practice or clinic in which the provider works. For example, if Dr. Jones is a physician employed by the Sunshine Health Center, both Dr. Jones and the Sunshine Health Center should be listed in the Directory since some enrollees might be looking at the directory specifically in search of Dr. Jones, while others may be concerned with assuring they can continue (or begin) to be treated at that particular health center.

Treatment of Direct Primary Care Medical Homes (42 CFR 156.245): We believe a direct primary care medical home must be one that has been recognized as a patient-centered medical home by an

accrediting organization. However, in establishing standards and listing those that would qualify as accrediting organizations, we request that that HHS align these standards and make sure that such list is consistent with the standards and organizations recognized by HRSA.

Thank you for the opportunity to comment on the provisions of the Notice of Proposed Rulemaking on Establishment of Exchanges and Qualified Health Plans. NACHC appreciates your consideration and favorable action on these comments.

Sincerely,

Roger Schwartz
Associate Vice President of Executive Branch Liaison
National Association of Community Health Centers