NATIONAL ASSOCIATION OF Community Health Centers

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December 22, 2015

Submitted via www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-9937-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Comments on Proposed Rule CMS-9937-P (RIN 0938-AS57) – Notice of Benefit and Payment Parameters for 2017

Dear Acting Administrator Slavitt:

The National Association of Community Health Centers, Inc. (NACHC) is pleased to submit the following comments in response to CMS-9937-P, the Notice of Benefit and Payment Parameters for 2017.

NACHC is the national membership organization for federally qualified health centers (FQHCs). With over 9,000 sites nationwide, FQHCs provide affordable, comprehensive primary care to over 24 million medically-underserved individuals. Our members include Community Health Centers, Migrant Health Centers, Health Care for the Homeless Grantees, and Public Housing Primary Care Grantees, all of whom who strive to meet the health care needs of the uninsured and underserved. For more general information on FQHCs, please see Attachment One.

Health centers serve a critical role in the success of the Marketplaces in every state, for two key reasons. First, we serve as the medical home for millions of Americans who are eligible for reduced-cost coverage through the Marketplace. While over 70% of health center patients live below the poverty line, over one-quarter of health center patients are above the poverty line. These individuals are frequently eligible for Marketplace coverage, including Advanced Premium Tax Credits (APTCs) and cost-sharing reductions. Second, health centers are a key source of outreach and enrollment (O&E) assistance nationally. Almost all Health Centers receive grants from the Health Resources and Services Administration (HRSA) to employ Certified Application Counselors (CACs). In 2014 alone, health centers employed over 7,000 CACs, and between July 2013 and June 2015, health center O&E staff assisted individuals with understanding and enrolling in their health insurance options over 12 million times.

This cover letter contains a summary of our comments, in the order in which they are addressed in the proposed regulatory text. For a detailed discussion of each comment, please see Attachment Two.

SUMMARY OF COMMENTS AND RECOMMENDATIONS FROM THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS ON THE DRAFT 2017 PAYMENT RULE

ENROLLMENT ASSISTANCE:

- §155.210(e)(8) – Navigators should be required to ensure that underserved and/or vulnerable populations within the Exchange service area receive targeted assistance, but not required to provide this targeted assistance directly.
- 155.210(e)(9) - NACHC supports expanding the role of – and training for – Navigators to include post-enrollment and related services, as this expanded role will more closely mirror the role currently played by Health Centers.
- §155.210(e)(9) – CMS should ensure that consumers fully understand the limitations on Navigators providing tax-related assistance. §155.210(b)(2)(v) through (viii) – CMS should carefully plan, monitor and update training for Navigators and other O&E providers, particularly around tax issues.
- §§155.210(d)(6) and 155.225(g)(4) – CMS should clarify what constitutes "inducement(s) for enrollment" and how they differ from "creative outreach and education strategies."
- §155.225(b)(1) - CMS should coordinate with HRSA on performance, registration, and reporting requirements that affect Certified Application Counselors at Health Centers.

GRACE PERIODS - §155.400(g)

- CMS should protect safety-net providers by requiring that QHPs pay claims for services rendered during the grace period.
- NACHC supports increasing flexibility around grace periods and disenrollment requirements provided that QHPs pay claims for services provided during months when they are collecting at least a portion of premiums.

OPEN ENROLLMENT PERIODS – §155.410(f)(2)(i) through (iii) - NACHC recommends that CMS better align Open Enrollment with tax season by scheduling the annual Open Enrollment Period from November 15 to March 15.

EXEMPTIONS - § 155.605(d)(5) – NACHC strongly supports CMS' proposal to eliminate unnecessary paperwork for individuals seeking an exemption from the shared responsibility payment due to their state's decision not to expand Medicaid.

STANDARDIZED OPTIONS - § 156.20

- NACHC supports CMS' proposals to establish standardized options for QHPs.
- NACHC strongly supports CMS' proposals to exempt primary care and generic drugs from the deductible in the bronze, silver, and gold standardized options.
- For the standardized option for Bronze plans, NACHC recommends reducing the cost-sharing amount and permitting more than 3 visits per year.

NETWORK ADEQUACY – §156.230

- While NACHC strongly supports CMS' goal of strengthening network adequacy requirements, we feel strongly that the proposals in the NPRM do not go nearly far enough.
- NACHC strongly encourages CMS to add additional metrics in the Federal default standard.

- CMS should consider adopting the network adequacy floor used by Medicare Advantage (MA), with added flexibility for states to go beyond those standards, such as by adding both travel time and geographic distance standards for rural areas.
- Regarding wait time standards for primary care visits, NACHC recommends that new patients should be required to wait no longer than 14 calendar days for a first-time appointment, and that at least 10% of all primary care appointments per day be available for same day access.
- NACHC supports allowing enrollees in "active treatment" to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates.
- NACHC supports counting cost sharing paid by an enrollee for an EHB provided by an out-of-network provider in an in-network setting towards the enrollee's annual limitation on cost sharing.
- CMS should state in regulatory language that all state-managed Exchanges must adhere to network adequacy standards that are at least as strong as the Federal standards.

ESSENTIAL COMMUNITY PROVIDERS (ECP) - §156.235(a)(2)(i)

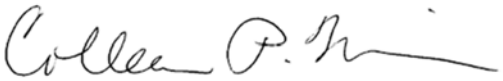
- CMS should institute an "any willing provider" requirement for QHPs to contract with ECPs.
- At a minimum, CMS should require QHPs to offer legally-compliant, good-faith contracts to all FQHCs in their service area.
- CMS state should explicitly in the Final Rule that QHPs may not contract directly with individual providers working within an ECP; rather, they must contract with the ECP as an entity.
- CMS should state in regulatory language that all state-managed Exchanges must adhere to standards around ECP contracting that are at least as strong as the Federal standards.

THIRD PARTY PAYMENT OF PREMIUMS - §156.1250

- NACHC strongly encourages CMS to require QHPs issuers to accept third-party payments from not-for-profit, charitable organizations, including health care providers, subject to appropriate "guardrails" designed to protect the risk pool.
- NACHC strongly urges CMS <u>not</u> to prohibit third parties premium payments for individuals and families caught in the "family glitch."
- NACHC strongly recommends that CMS (and HRSA) explicitly permit FQHCs to pay for individuals' QHP premiums using "non-program income."
- CMS should clearly state that third-party premium payments authorized under this section are not considered "remuneration" for purposes of the Anti-Kickback statute (AKS) statute
- CMS should clarify that entities that are permitted to make third-party premium payments are not required to do so.

In closing, NACHC appreciates the effort that went into preparing this NPRM, and while we would have appreciated a longer review period, we thank you for the opportunity to comment on it. If you require any clarification on our comments, please contact Ms. Colleen Meiman, NACHC's Director of Regulatory Affairs, at 202-296-0158 or cmeiman@nachc.org.

Sincerely,



Colleen P. Meiman, MPPA
Director of Regulatory Affairs
National Association of Community Health Centers

Attachment One:

OVERVIEW OF FEDERALLY QUALIFIED HEALTH CENTERS

For 50 years, Health Centers have provided access to quality and affordable primary and preventive healthcare services to millions of uninsured and medically underserved people nationwide, regardless of their ability to pay. At present there are almost 1,300 health centers with more than 9,300 sites. Together, they serve ***over 24 million patients***, including nearly seven million children and more than 1 in 7 Medicaid beneficiaries.

Health centers provide care to all individuals, regardless of their ability to pay. All health centers provide a full range of primary and preventive services, as well as services that enable patients to access health care appropriately (e.g., translation, health education, transportation). A growing number of Health Centers also provide dental, behavioral health, pharmacy, and other important supplemental services.

To be approved by the Federal government as a Health Center, an organization must meet requirements outlined in § 330 of the Public Health Service Act. These requirements include, but are not limited to:

- ***Serve a federally-designated medically underserved area or a medically underserved population.*** Some Health Centers serve an entire community, while other target specific populations, such as persons experiencing homelessness or migrant farmworkers.
- Offer services to all persons, regardless of the person's ability to pay.
- Charge no more than a nominal fee to patients whose incomes are at or below the Federal Poverty Level (FPL).
- Charge persons whose incomes are between 101% and 200% FPL based on a sliding fee scale
- Be ***governed by a board of directors, of whom a majority of members must be patients of the health center.***

Most § 330 Health Centers receive Federal grants from the Bureau of Primary Health Care (BPHC) within HRSA. BPHC's grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing care to uninsured and underinsured indigent patients, as well as to maintain the health center's infrastructure. Patients who are not indigent or who have insurance, whether public or private, are expected to pay for the services rendered. In 2013, on average, the insurance status of Health Center patients is as follows:

- 41% are Medicaid recipients
- 35% are uninsured
- 14% are privately insured
- 8% are Medicare recipients

No two health centers are alike, but they all share one common purpose: to provide primary health care services that are coordinated, culturally and linguistically competent, and community-directed care to uninsured and medically underserved people.

Attachment Two:

DETAILED COMMENTS ON DRAFT 2017 PAYMENT RULE FROM THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

December 2015

ENROLLMENT ASSISTANCE: §§ 155.205, 155.210, and 155.215 While Health Centers' Outreach and Enrollment (O&E) workers are generally Certified Assistance Counselors (CACs), NACHC has a strong interest in the Navigator and Non Navigator assistance personnel programs. This is because all three types of assisters have a shared mission of providing outreach, education, and enrollment assistance to those in need. In addition, some Health Centers and state Primary Care Associations also serve as Navigators or non-Navigator assistance personnel. Therefore, our comments on this section reflect both our shared mission and our experience assisting consumers with over 12 million times with O&E activities.

NACHC is generally supportive of CMS' proposals, as we think most of them will help to strengthen the Navigator and Non Navigator programs. However, we want to ensure that these requirements do not become overly burdensome for the individuals providing the assistance. In addition, we are cautiously supportive of the provisions surrounding providing tax assistance, as Navigators are not allowed to provide tax assistance; as discussed below, we seek clear and precise definitions and trainings on what will be expected of Navigators in this area. We also request that the Exchanges commit to offering thorough trainings on these new requirements.

Specifically:

- **§155.210(e)(8) – NACHC recommends that Navigators be required to ensure that underserved and/or vulnerable populations within the Exchange service area receive targeted assistance, but not required to provide this targeted assistance directly.** NACHC appreciates CMS' focus on the needs of underserved and/or vulnerable populations, as demonstrated by the proposal to require Navigators in all Exchanges to provide targeted assistance to these populations within the Exchange service area. However, we are concerned that *requiring* Navigators to provide this assistance *directly* could be often redundant and inefficient.

  Under the terms of their Outreach and Enrollment (O&E) grants from HRSA, Health Centers are required to offer O&E services to their patients and the surrounding community. By law, Health Centers target medically underserved areas and populations; therefore, they have been providing a full range of O&E services to the underserved and/or vulnerable populations in their services areas, generally since 2013. Requiring Navigators to target populations already served by Health Centers is redundant, and will result in resources being diverted from areas where they could be used more effectively. For these reasons, NACHC recommends that Navigators be required to coordinate with other official O&E providers (e.g., Navigators, non-Navigator assistance personnel, and Certified Application Counselors, including those in Health Centers) in each service area to ensure that all underserved and/or vulnerable populations are receiving targeted assistance. However, if another official O&E provider is already provided targeted services to an underserved and/or vulnerable population, the Navigator should not be required to provide this assistance directly.

In addition, we support the proposal to permit FFE Navigator grant applicants an opportunity to proposed vulnerable and/or underserved communities beyond those identified by in the Funding Opportunity Announcement, and we recommend that this proposal be expanded to State-Based and State-Partnership Exchanges.

- **155.210(e)(9) - NACHC supports expanding the role of – and training for – Navigators to include post-enrollment and related services, as this expanded role will more closely mirror the role currently played by Health Centers.** NACHC supports the proposal to expand the types of assistance which Navigators will provide, to include post-enrollment services (e.g., filing eligibility appeals, understanding how to use coverage effectively, applying for exemptions) Health Centers have provided these services to clients since the first Open Enrollment Period, and have found that they are very beneficial to patients.

- **§155.210(e)(9) – NACHC recommends that CMS ensure that consumers fully understand the limitations on Navigators providing tax-related assistance.** As mentioned above, NACHC is cautiously supportive of the proposals to require Navigators to provide assistance on tax-related issues, such as "explaining the general purpose of Internal Revenue Service (IRS) Form 8965 to consumers,… and explaining how to access this form and related tax information on irs.gov." We also agree that Navigators should not provide tax assistance or interpret tax rules. Given these distinctions, NACHC thinks it is important that consumers be clearly informed about the limitations of the Navigators' role regarding tax information. We therefore support CMS' proposal that "prior to providing this information and assistance *[regarding tax forms]*, Navigators provide consumers with a disclaimer stating that they are not acting as tax advisers and cannot provide tax advice". We recommend that this disclaimer be provided both verbally and in writing, and in a linguistically-appropriate manner.

- **§155.210(b)(2)(v) through (viii) – CMS should carefully plan, monitor and update training for Navigators and other O&E providers, particularly around tax issues.** NACHC appreciates CMS's statement that:

  > "To ensure that Navigators in all States receive training in every area for which there would be a corresponding Navigator duty, we propose to require all Exchanges, including State Exchanges, to provide training that would prepare Navigators for the additional areas of responsibility proposed in this rulemaking."

  Given Health Centers' extensive experience in O&E activities, we wish to emphasize the critical importance of this training, particularly around tax issues. We therefore recommend that CMS invest significant effort in developing, monitoring, and updating training for Navigators and other O&E staff.

§§155.210(d)(6) and 155.225(g)(4) – CMS should clarify what constitutes "inducement(s) for enrollment" and how they differ from "creative outreach and education strategies". NACHC appreciates the additional information provided in the NPRM regarding the use of promotional items and gift. However, we request further clarification about what constitutes an "inducement to enrollment" and how this differs from "creative outreach strategies." We also ask CMS to consider how a proposal to ban all gifts of any value could adversely impact or complicate events such as health fairs that consist of multiple organizations or hosts that offer a drawing for an item that exceeds nominal value. We contend that these types of activities are not inducements for enrollment, given that the drawings are not limited to those who enroll; however, we request CMS clarification on this point. Also, please note that to the extent that CMS' proposed restrictions on

gifts conflict with the exemptions from the beneficiary inducement rules, this may create difficulties for Navigators that are health care providers. The beneficiary inducement rules apply to Medicare and "state health care programs" (Medicaid, CHIP), and items of nominal value are excepted from the prohibition on offering items of value to patients. The OIG has defined the exception as permitting gifts of less than $10 individually or less than $50 per patient annually.

- **§155.225(b)(1) - CMS should coordinate with HRSA on performance, registration, and reporting requirements that affect Certified Application Counselors at Health Centers**. As stated previously, most Health Centers receive grant funding from HRSA to serve as CACs. These grant funds come with numerous conditions, around both performance and reporting. In general, we request that CMS work with HRSA when finalizing these rules to ensure that no requirements in this rule contradict or are duplicative of requirements under the HRSA CAC grants. For example, proposed §155.225(b)(1) states that each CAC-designated organization must provide the Exchange with information and data related to the number and performance of its CACs and the assistance they provide. Since Health Centers are report this type of data to HRSA, we request that CMS and HRSA work collaboratively to align these requirements, thereby ensuring that Health Centers are not subject to duplicative or overly burdensome reporting demands. We also encourage CMS and the Exchanges to coordinate with HRSA when "designating" Health Centers as CAC entities, again with the goal of avoiding duplicative requirements.

GRACE PERIODS - §155.400(g)

- **CMS should protect safety-net providers by requiring that QHPs pay claims for services rendered during the grace period.** NACHC supports the concept of grace periods, as they allow enrollees who are delinquent in premium payment to maintain their coverage for a limited period of time. However, under current CMS policy, QHPs are not required to pay claims associated with services rendered during months two and three of an enrollee's grace period. As a result, it is the provider – not the QHP – who bears the full financial cost of services provided during this time. This policy is particularly problematic for health centers, as they cannot turn these patients away; rather, they treat all patients regardless of insurance status or ability to pay, and therefore absorb the full cost of providing care.

- **NACHC supports increasing flexibility around grace periods and disenrollment requirements provided that QHPs pay claims for services provided during months when they are collecting at least a portion of premiums.** NACHC supports the intention behind CMS' proposal to allow issuers to maintain coverage when an enrollee is overdue on only a portion of their premium. This proposal would be beneficial to enrollees, as it would protect them from having their coverage terminated when they owe only a minimal amount. However, we are very concerned that, if implemented, his policy would further exacerbate the situation described above, in which FQHCs and other providers are forced to bear the full cost of care provided to individuals who are in their second or later month of a grace period. We therefore recommend, at a minimum, that QHP issuers should be required to pay for services provided to enrollees for any period in which they are collecting a portion of the premium.

OPEN ENROLLMENT PERIODS – §155.410(f)(2)(i) through (iii) – NACHC recommends that CMS better align Open Enrollment with tax season by scheduling the annual Open Enrollment Period from November 15 to March 15. NACHC supports CMS' proposal to start the Marketplace's annual Open Enrollment Period (OEP) in November, as this coincides with the OEPs for many Employer-Sponsored Insurance plans. However, given the connections among Marketplace coverage, shared responsibility

payments, and the tax code, NACHC also thinks that the annual OEP should be aligned with tax preparation season. Tax time is an excellent time for individuals to enroll, as it is the time when they are most aware of their earnings from the previous year and able to predict future income; it is also when awareness of the shared responsibility payments is at its highest.

For these reasons, NACHC recommends that CMS establish an annual OEP of November 15 – March 15. The November 15 date will provide some overlap with most end-of-year OEPs for employer-sponsored insurance. In addition, while a March 15 end date will not cover the entire tax preparation season, the majority of lower-income taxpayers typically file their taxes early, so this end date will encompass many of them.

EXEMPTIONS - § 155.605(d)(5) – NACHC strongly supports CMS' proposal to eliminate unnecessary paperwork for individuals seeking an exemption from the shared responsibility payment due to their state's decision not to expand Medicaid. Specifically, we support CMS's proposal to remove the requirement that individuals who are ineligible for Medicaid due to their state's not implementing the ACA expansion must apply to Medicaid and receive a rejection prior to seeking an exemption.

STANDARDIZED OPTIONS - § 156.20

- **NACHC supports CMS' proposals to establish standardized options for QHPs**, as this will make it easier for clients to compare plans and select the one most appropriate to their situation.

- **NACHC strongly supports CMS' proposals to exempt primary care and generic drugs from the deductible in the bronze, silver, and gold standardized options.** Since Marketplace coverage began in 2014, many newly-insured patients have found themselves unable to afford basic care – e.g., primary care and generic drugs -- because they cannot afford to pay full price out-of-pocket until they reach their deductible. Not only is this short-sighted -- as it discourages individuals from seeking care when illnesses may be more easily treated-- but it undermines efforts to educate individuals about the need for and value of insurance, as many of them (particularly the healthy ones) fail to see any immediate benefits. Therefore, NACHC strongly supports CMS' proposals to include first-dollar coverage for primary care and generic drugs as part of the standardized options, as this should encourage more QHPs to offer these benefits, resulting in more enrollees receiving them.

  High-deductible plans without first-dollar coverage have a direct, negative financial impact on Health Centers, as well as patients. Unlike other provider types, Health Centers will never turn away patients who cannot afford to pay for their care. If one of our patients is insured but cannot pay the amount due under their insurance, we charge them only the amount they would pay if they were uninsured (as determined by our sliding fee scale based on income.) As a result, it is the Health Center – not the patient or the QHP – who bears much of the cost of the high deductible.

- **For the standardized option for Bronze plans, NACHC recommends reducing the cost-sharing amount and permitting more than 3 visits per year.** Requiring standard option Bronze plans to cover 3 primary care visits at $45 each outside the deductible is a step in the right direction. However, NACHC thinks that it does not go far enough. As discussed above, high out-of-pocket costs for primary care and maintenance drugs discourage patients from seeking such care, which often results in higher costs in the long run; it discourages healthy individuals from purchasing insurance. We therefore recommend that CMS increase the number of primary care visits covered,

and reduce the cost-sharing to a level that is more affordable for the type of individuals and families who tend to purchase Bronze coverage.

NETWORK ADEQUACY – §156.230 –

- **While NACHC strongly supports CMS' goal of strengthening network adequacy requirements, we feel strongly that the proposals in the NPRM do not go nearly far enough.** While we appreciate CMS' gradual efforts to strengthen network adequacy standards for QHPs, we feel strongly that CMS has moved too slowly in this area, and that this year's proposal is too weak. Specifically, the proposed Federal default standard at §156.230(d) is limited to time and distance measured at the county level, "focusing on the specialties that enrollees most generally use." This is much too narrow of a standard because:
  - In rural areas, time-and-distance is an appropriate general standard, but taken by itself it is insufficient, as it fails to take into account access for individuals with special needs, such as disabilities and Limited English Proficiency (LEP.) In addition, time-and-distance standards are only useful for the types of services to which they are applied. The NPRM states that CMS will apply this standard to "the specialties that enrollees most generally use." Without further clarification, this could be interpreted as applying to as few as two specialties. Also, this standard fails to assess access to various type of services (e.g.,, diagnostic, pharmacy) in addition to types of specialties.
  - In more populated areas, time-and-distance standards are of very limited usefulness. For example, in an underserved urban area, a QHP with a low number of providers relative to the size of the patient population would score well on a time-and-distance standard (because it would not take long for patients to travel to the providers' offices) but patients could face extremely long waits to get appointments.

- Given these inadequacies, **NACHC strongly encourages CMS to add additional metrics in the Federal default standard.** These additional metrics should include:
  - a minimum ratio of providers-to-covered-persons for primary care providers and for a range of specialists by specialty (including subspecialists);
  - maximum wait times to get a primary care appointment, for first-time and returning patients
  - a maximum time and distance standard to access primary care and specialists (by specialty);
  - a maximum time and distance standard to access hospital, emergency care, diagnostic, pharmacy, and ancillary services;
  - a minimum number of providers to meet the needs of individuals with limited English proficiency (LEP); and
  - a minimum number of providers to meet the needs of consumers with disabilities.

  The actual ratio standards, time and distance standards, specialties and subspecialties, and LEP provider ratios should be set according to an evidence-based review of the actual patterns of care. Exception requests from regulatory standards should be carefully scrutinized and approved only when necessary.

- **CMS should consider adopting the network adequacy floor used by Medicare Advantage (MA), with added flexibility for states to go beyond those standards, such as by adding both travel time and geographic distance standards for rural areas.** MA provides an example of well-regarded network adequacy standards and administrative requirements. The MA standards allow for efficient accessibility, measure network adequacy for a large swath of provider types, and vary by population density to reflect the specific needs of non-metro, rural, and frontier areas. However, the Medicare Advantage model has a significant weakness in that it applies travel time standards only to

metropolitan areas, and applies only geographic distance standards in non-metro counties. As rural communities face many geographic and weather-related barriers that significantly slow travel time, travel time measures should be applied in these areas as well.

- **Regarding wait time standards for primary care visits, NACHC recommends that new patients should be required to wait no longer than 14 calendar days for a first-time appointment, and that at least 10% of all primary care appointments per day be available for same day access.** These recommendations are based on surveys of our patients, and input from our providers.

- **NACHC supports the following proposals offered by CMS:**
  - §156.230(e)(2) - When provider is terminated without cause, QHPs must allow enrollees in "active treatment" to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates.
  - 156.230(f) - Under certain circumstances, QHPs must count cost sharing paid by an enrollee for an EHB provided by an out-of-network provider in an in-network setting towards the enrollee's annual limitation on cost sharing.

- **CMS should state in regulatory language that all state-managed Exchanges must adhere to network adequacy standards that are at least as strong as the Federal standards.** To the best of our knowledge, current regulations do not state that State-managed Exchanges (including State-Based Exchanges, State–Based Exchanges on the Federal Platform, and State-Partnership Exchanges) must adhere to network adequacy standards that are at least as strong as those being used in the FFEs. We therefore recommend that CMS add regulatory language addressing this issue, and that it also make clear that states have the option to impose stricter standards.

ESSENTIAL COMMUNITY PROVIDERS (ECP) - §156.235(a)(2)(i)

- **CMS should institute an "any willing provider" requirement for QHPs to contract with ECPs.** Section 1311 of the ACA states that QHPs "shall... include... those essential community providers, where available, that serve predominately low-income, medically-underserved individuals". As NACHC has stated in previous comments, we think that this language clearly requires QHP issuers to offer-good faith contracts to <u>all</u> ECPs (as defined in the statute) located in their service areas. For this reason, we repeat our request that CMS institute an "any willing provider" requirement for QHP contracting with ECPs, in all types of Marketplaces.

- **At a minimum, CMS should require QHPs to offer legally-compliant, good-faith contracts to all FQHCs in their service areas.** As we have mentioned in past comments, improving access to primary care is a leading tenet of the ACA, and ensuring adequate access to primary care services is a critical component of any QHP network. FQHCs are the largest single source of primary care in medically underserved areas and for medically underserved populations. Thus, to ensure meaningful primary care access for low-income and medically underserved QHP enrollees, CMS should at a minimum require QHPs to offer good-faith contracts to all FQHCs in their service areas.

- **CMS state should explicitly in the Final Rule that QHPs may not contract directly with individual providers working within an ECP; rather, they must contract with the ECP as an entity.** In the past, some QHPs have sought to contract directly with individual providers who work for an FQHC, as

opposed to the FQHC itself. This approach has enabled QHPs to undermine the intent behind the ECP contracting provisions, while also creating unnecessary confusion and burden for both providers and patients.

- **CMS should state in regulatory language that all state-managed Exchanges must adhere to standards around ECP contracting that are at least as strong as the Federal standards.** To the best of our knowledge, current regulations do not state that State-managed Exchanges (including State-Based Exchanges, State–Based Exchanges on the Federal Platform, and State-Partnership Exchanges) must adhere to ECP contracting standards that are at least as strong as those being used in the FFEs. We therefore recommend that CMS add regulatory language addressing this issue, and that it also make clear that states have the option to impose stricter standards.

THIRD PARTY PAYMENT OF PREMIUMS - §156.1250

- **NACHC strongly encourages CMS to require QHPs issuers to accept third-party payments from not-for-profit, charitable organizations, including health care providers, subject to appropriate "guardrails" designed to protect the risk pool.** Expanding the types of organizations that may assist Marketplace enrollees with their premiums will significantly expand the impact of the ACA, as it will make it easier for many individuals to enroll in QHP coverage. It would also increase fairness, as individuals with HIV/AIDS are currently eligible for these payments, while individuals who other illnesses are not – despite the fact that not-for-profit, charitable organizations are willing to provide them on their behalf. NACHC understands that permitting third-party payments could create concerns about biasing the risk pool, particularly if these payments are made by health care providers who may care for the newly-insured patients. However, these concerns could be offset by establishing appropriate "guardrails" designed to prevent skewing the risk pool. Examples of such guardrails include requiring that organizations have an explicit set of rules for determining which individuals receive assistance and apply them consistently, and requiring that assistance be provided for a minimum length of time. However, please note the comment below about one type of guardrail that would not be appropriate.
- **NACHC requests that CMS explicitly list FQHCs as one of the types of not-for-profit, charitable organizations from whom QHPs must accept third-party premium payments:** We also recommend that CMS explicitly list FQHCs in the regulatory text as one of the types of entities that are eligible to make third-party premium payments - and from whom QHPs must accept such payments – provided that they meet the requirements established for all other not-for-profit, charitable organizations. While we recognize that there may be limitations on the ability of FQHC to finance these payments using HRSA grant funds, these limitations should be addressed by HRSA rather than CMS.
- **NACHC strongly urges CMS not to prohibit third-party premium payments for individuals and families caught in the "family glitch."** In the preamble, CMS lists examples of potential "guardrails" that could be placed around third-party payments to prevent biasing the risk pool. While we support appropriate guardrails, we are very concerned about one of the examples provided – specifically, limiting assistance to individuals not eligible for other Minimum Essential Coverage (MEC.) While this restriction may be appropriate for some types of MEC, it would prohibit third-party payments for families who are caught by "family glitch." As you are aware, this "glitch" is prohibiting millions of families from being eligible for APTCs and cost-sharing reductions through the Marketplace, even though the cost of family coverage through an employer is well beyond their reach. Thus, if CMS decides to place "guardrails" around eligibility for third-party payments, we strongly urge that these rules not prohibit third-party payments for families caught in the "family glitch."

- **CMS should clearly state that third-party premium payments authorized under this section are not considered "remuneration" for purposes of the Anti-Kickback statute (AKS) statute.** If a Health Center or other not-for-profit charitable organizations assistance provides premium assistance under this section, it would be intended to increase access to health care services, and not as an inducement to refer individuals to the entity or as an inducement to purchase, lease, order or arrange for services or items that may be paid for under a "federal health care program."[1] In the unlikely event that the HHS Office of Inspector General (HHS OIG) informed an entity that it considered the premium assistance payments as improper remuneration, however, the entity could not invoke any specific AKS safe harbor. Therefore, we request that CMS at minimum provide assurance in the preamble to the Final Rule that it does not consider the premium assistance to be "remuneration." Preferably, CMS should consult with HHS OIG on this point in order to ensure that HHS OIG is in agreement.
- **CMS should clarify that entities that are permitted to make third-party premium payments are not required to do so.** In addition, NACHC requests that CMS clarify in the preamble to the Final Rule that merely because a QHP issuer is required to accept premium assistance payments from an entity per § 156.1250, that does not mean that the donor entity has any obligation to provide such payments with respect to an individual enrollee. Instead, the terms of the premium assistance (including its scope and whether it is mandatory or voluntary) are governed by the terms of the relevant federal or state government program.

[1] In this regard, we note that Former HHS Secretary Sebelius' October 30, 2013 letter to U.S. Representative Jim McDermott, opining that HHS "does not consider QHPs, other programs related to the Federally-facilitated Marketplace, and other programs under Title I of the [ACA] [including the cost sharing reduction and premium tax credit] to be federal health care programs," is of some comfort. However, that communication does not completely dispel the concerns of health centers and other similarly-situated entities that assist with premiums and cost-sharing (such as Ryan White providers and Indian Health Service providers), for two reasons. First, Sec. Sebelius' letter is not binding legal authority. Second, the very federal programs that fund health centers, Ryan White providers, and Indian Health Service providers could, themselves, be considered "federal health care programs."