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March 7, 2017

The Honorable Tom Price
Patrick Conway, CMS Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services,
Attention: CMS-9929-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted via www.regulations.gov

SUBJECT: CMS–9929–P; Proposed Rule for Patient Protection and Affordable Care Act Market Stabilization

Dear Secretary Price and Acting Administrator Conway:

The National Association of Community Health Centers is pleased to respond to CMS–9929–P; Proposed Rule for Patient Protection and Affordable Care Act Market Stabilization, published on February 15, 2017. NACHC is the national membership organization for federally qualified health centers (FQHCs or "health centers"). With over 9,800 sites nationwide, FQHCs provide affordable, comprehensive primary care to over 25 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 strive to meet the health care needs of the uninsured and underserved. For more general information on FQHCs, please see the attachment.

Health centers serve a critical role in the success of the Marketplaces in every state, serving as the medical home for millions of Americans who are eligible for reduced-cost coverage through the Marketplace. While over 70 percent 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 enrolled in Marketplace coverage, and may receive Advanced Premium Tax Credits and cost-sharing reductions. Additionally, health centers are a key source of outreach and enrollment (O&E) assistance nationally. With support from the Health Resources and Services Administration (HRSA), and often from CMS programs, FQHCs have assisted over 15 million people in their efforts to become insured since fall 2013. This assistance includes helping individuals enroll in Medicaid, CHIP, Medicare, or the Marketplace; it also includes assisting

individuals with re-enrollments/renewals, obtaining exemptions, and understanding and utilizing their newly-acquired insurance.

We begin with a summary of our comments, followed by a detailed discussion of each.

SUMMARY OF NACHC'S COMMENTS

Contracting with Essential Community Providers

- NACHC strongly opposes the proposal to reduce the requirement that QHPs to contract with 30% of all Essential Community Providers (ECPs) in their service area to 20%, as this proposal:
    - Is inconsistent with – and moves further away from – statutory requirements.
    - Will lead to less consistency and coordination of care for patients.
    - Will lead to higher long-term costs for insurers.
- NACHC strongly recommends that any ECP that is "written in" on a QHP's application be approved by CMS as an ECP before it is counted towards the QHP's contracting percentage.

Shortened Open Enrollment Period

- NACHC recommends that CMS retain the originally-scheduled three-month Open Enrollment Period (OEP) for 2018, as reducing the OEP by half could weaken -- rather than improve -- the risk-pool, and will disadvantage consumers in need of enrollment assistance.
- If the OEP is shortened, CMS should continue to fund Navigators at no less than current levels, due to Navigators' critical role in ensuring robust enrollment and the significantly increased demands for their services during the shorter OEP.

Network Adequacy

- Regarding network adequacy, NACHC opposes CMS' proposal to eliminate the use of time-and-distance standards, and instead default entirely to state oversight; rather, CMS should institute minimum national standards with state flexibility to go beyond those standards.

Payment of Back Premiums

- NACHC recommends that CMS establish a clear and efficient appeals process for individuals who are barred from re-enrolling in a plan due to claims of non-payment of earlier premiums.

Public Education Campaign

- NACHC strongly supports CMS plans to engage in a broad-based, multi-media education campaign to alert consumers to upcoming changes to the Marketplaces, including the shortening of the OEP. This campaign should begin well before the start of Open Enrollment, and be provided through multiple venues and in multiple languages.

DETAILED COMMENTS

NACHC appreciates CMS' efforts to stabilize the Marketplaces, as they provide an important coverage source for health center patients, and millions of other individuals across the nation. In particular we support:

- The issuance of a revised timeline for the QHP certification and rate review process for plan year 2018, as these relaxed timeframes will give issuers additional time to implement proposed changes;
- General efforts to encourage continuous coverage;
- Requiring verification of eligibility in order to enroll during a Special Enrollment Period;
- CMS' plans to ensure a robust outreach strategy to educate consumers about upcoming changes to the Marketplace.

<u>Contracting with Essential Community Providers (ECPs)</u>

- **NACHC strongly opposes the proposal to reduce the requirement that QHPs to contract with 30% of all Essential Community Providers (ECPs) in their service area to 20%, as this proposal:**
    - **Is inconsistent with – and moves further away from – statutory requirements.**
    - **Will lead to less consistency and coordination of care for patients.**
    - **Will lead to higher long-term costs for insurers.**

  Section 1311(c)(1)(C) of the Affordable Care Act states that:

  > "a plan shall, at a minimum… 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…."

  This statutory language makes clear that Congress intended for QHPs to include <u>all</u> ECPs located in their service area in their provider networks – not just a subset.

  Thus, the existing policy requiring all QHPs to contract with at least 30% of all ECPs in their service area is already inconsistent with a plain reading of the statute. The proposal to reduce this percentage to 20% moves even further away from the statutory requirement.

  Not only is this proposal inconsistent with clear statutory requirements, but it is also detrimental to patients and insurers. Many patients with Marketplace coverage regularly "churn" among Medicaid coverage, Marketplace coverage, and being uninsured. FQHCs provide a stable, consistent medical home for these patients, regardless of their insurance status; they also lead to lower total costs for insurers by reducing these individuals' <u>total</u>

medical costs over time (through reduced ER visits, hospitalizations, etc.[1]) Thus, reducing QHPs' patients' access to FQHCs will lead to less consistent, coordinated care for patients, as well as higher long-term costs for payers.

- **NACHC strongly recommends that any ECP that is "written in" on a QHP's application be approved by CMS as an ECP before it is counted towards the QHP's contracting percentage.** We appreciate that CMS has proposed that any ECP candidates who are "written in" on a QHP's application must apply to be included on the HHS ECP database at the same time. However, as described in the NPRM text, there does not appear to be a mechanism for ensuring that the write-in candidate actually meets the qualifications to be an ECP in order for the QHP to count it towards meeting its contracting threshold. We therefore strongly urge that CMS ensure that "write-ins" truly qualify as ECPs before a QHP can count it toward the contracting threshold.

Open Enrollment Period

- **NACHC recommends that CMS retain the originally-scheduled three-month Open Enrollment Period (OEP) for 2018, as reducing the OEP by half could weaken -- rather than improve -- the risk-pool, and will disadvantage consumers in need of enrollment assistance.** NACHC supports CMS' goal of strengthening the Marketplace risk pools. However, we are concerned that the proposal to shorten the OEP from three months to six weeks will actually have the opposite effect, as it will decrease the likelihood of young, healthier persons enrolling in coverage. Research consistently shows that consumers with ongoing medical needs are the most motivated to enroll, and therefore the most likely to enroll during a shorter OEP. In contrast, younger and healthier individuals are less likely to focus on enrollment issues and therefore more likely to miss a shorter window. In addition, ending the OEP in December makes it even more likely that younger, healthier individuals will fail to enroll as this is when consumer have heightened financial constraints and are distracted by the holiday season.[2] As Florida Blue Cross Blue Shield noted, ending an OEP in December "forces consumers to make financial decisions when their debt is at its highest levels and their interest in their health is at the lowest."[3]

  In addition to decreasing enrollment among younger and healthier individuals, shortening the OEP will make it more difficult for people who need assistance to enroll in coverage to receive appropriate support. Research has shown that consumers who enroll with the help

[1] Nocon, Robert S, et al. Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings (Amer. Journal of Public Health, February 2017) Available online at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5055764/

[2] Stan Dorn, *Enrollment Periods in 2015 and Beyond: Potential Effects on Enrollment and Program Administration (Washington DC: Urban Institute, February 2015)*, available online at: http://www.urban.org/sites/default/files/publication/41616/2000104-Enrollment-Periods-in-2015-and-Beyond.pdf.

[3] See Florida Blue Cross Blue Shield's comments on the Benefit and Payment Parameter Rule for 2018, here: https://www.regulations.gov/document?D=CMS-2016-0148-0492

of assisters (e.g., Navigators, certified application counselors (CACs), and other in-person assisters (IPAs)) are nearly twice as likely to successfully enroll as those enrolling online without help[4]; for this reason, ensuring the availability of these assisters is critical to ensuring robust enrollment, particularly among populations who are less familiar with health insurance. Unfortunately, shortening the OEP will substantially compress the demand for assister services -- leading to lower overall enrollment.

We appreciate that CMS is specifically seeking comment on the effect of the shortened OEP on assisters and Navigators, CACs, and IPAs, because we believe the effects will be substantial. Even with longer OEPs, these assisters have been stretched to capacity and had to turn consumers away during times of high demand[5]; cutting the OEP in half will only exacerbate these issues.

- **If the OEP is shortened, CMS should continue to fund Navigators at no less than current levels, due to Navigators' critical role in ensuring robust enrollment and the significantly increased demands for their services during the shorter OEP.** As discussed above, cutting the OEP in half will dramatically increase the demand for Navigator and other assisters to support enrollees during this period. Given the important role that they play in ensuring robust, diverse enrollment, NACHC urges CMS to continue to fund Navigator grants at levels that are at least as high as the current year.

Network Adequacy

- **Regarding network adequacy, NACHC opposes CMS' proposal to eliminate the use of time-and-distance standards, and instead default entirely to state oversight; rather, CMS should institute minimum national standards with state flexibility to go beyond those standards.**
  For the 2016 and 2017 plan years, when determining if QHPs in Federally-Facilitated Exchanges (FFEs) met the "reasonable access" standard for network adequacy, CMS applied maximum time-and-distance standards for specific types of services and specialties. In this NPRM, CMS states that for the 2018 plan year, it will no longer apply the time-and-distance standards; rather, it will rely entirely on state-level reviews of network adequacy, or – for states without the authority or capacity to conduct such reviews – on the QHP's accreditation.

  NACHC opposes the proposal to eliminate the time-and-distance evaluation and rely entirely on state-level review. At present nearly half of states have no metrics in place to

[4] Zach Baron, *In Person Assistance Maximizes Enrollment Success* (Washington: Enroll America, March 2014), available online at: https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/12/In-Person-Assistance-Success.pdf.

[5] Karen Pollitz, Jennifer Tolbert, and Rosa Ma, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers (*Washington: Kaiser Family Foundation, August 2015), available online at: http://files.kff.org/attachment/report-2015-survey-of-health-insurance-marketplace-assister-programs-and-brokers.

assess whether QHPs provide adequate networks,[6] raising concerns that QHPs in these states could be approved despite very sparse networks.

At the same time, we recognize states' historic role in evaluating network adequacy. We believe that these two concerns can both be addressed by having CMS establish minimum national standards for network adequacy, with states having the flexibility to expand on these standards as they deem appropriate.

Payment of Back Premiums

- **NACHC recommends that CMS establish a clear and efficient appeals process for individuals who are barred from re-enrolling in a plan due to claims of non-payment of earlier premiums.**

The NPRM proposes to incentivize patients to avoid coverage lapses by allowing an issuer to collect premiums for prior unpaid coverage, before enrolling in the next year's plan with the same issuer. While we support efforts to prevent "gaming the system", we are concerned that this proposal could block individuals from receiving coverage in situations where there has been a clerical error, and/or when a genuine medical hardship prevented the payment of premiums.

We are particularly concerned that this provision could create a mechanism for issuers to deny coverage from consumers who experience high use of medical services. A consumer who becomes injured or ill, and therefore unable to work, may experience a significant loss of income and therefore be unable to cover their premiums at the time when they most need medical care. While these individuals may qualify for reduced premiums or Medicaid coverage during these episodes, a disabled individual is often unable to apply for such changes in "real time," leading to unpaid QHP premium amounts that no longer reflect their actual economic situation. Because of past rescission abuses by some issuers, NACHC believes consumers deserve some form of procedural "guard rails" to prevent inappropriate or arbitrary loss of coverage in these situations.
In addition, some individuals lose their Advanced Premium Tax Credits due to a Marketplace error, or because they did not receive/understand a Marketplace electronic communication. When the problem is resolved they are often unaware that they can choose for their tax credits to be applied retroactively. This oversight leaves consumers on the hook for arrearages of the full premium costs.

For these reasons, NACHC recommends that CMS require a clear and efficient appeals process to enable these issues to be considered before an individual is denied coverage.

[6] Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, Implementing the Affordable Care Act:
State Regulation of Marketplace Plan Provider Networks (Washington, DC: Georgetown CHIR, May 2015), available online at:
http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf

This process should allow consumers to seek to have their eligibility for APTCs reassessed retroactive to the onset of illness or injury; to resolve Marketplace errors; to apply tax credits retroactively; and/ or to negotiate a settlement so they are not blocked from accessing coverage.

Public Education Campaign

- **Finally, NACHC strongly supports CMS plans to engage in a broad-based, multi-media education campaign to alert consumers to upcoming changes to the Marketplaces, including the shortening of the OEP. This campaign should begin well before the start of Open Enrollment, and be provided through multiple venues and in multiple languages.** Based on the proposals in this NPRM, issues to be addressed in this campaign should include (but are not necessarily limited to:
    - The shortened Open Enrollment period;
    - Potential penalties for non-payment of premiums upon re-enrollment in the same plan, and the availability of an appeals process in these situations;
    - Increased requirements for validating eligibility for SEPs.

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In closing, we appreciate the opportunity to submit comments on this NPRM. NACHC and our member health centers would be happy to provide any further information that would be helpful.

Sincerely,

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Director, Regulatory Affairs
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Attachment A:
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 over 1,400 health centers with more than 9,800 sites. Together, they serve ***over 25 million patients***, including nearly eight million children and more than 1 in 6 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 2015, on average, the insurance status of Health Center patients is as follows:

- 49% are Medicaid or CHIP recipients
- 24% are uninsured
- 17% are privately insured
- 9% are Medicare recipients

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