NATIONAL ASSOCIATION OF Community Health Centers

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Submitted electronically via http://www.regulations.gov

Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-9934-P
P.O. Box 8016
Baltimore, MD 21244-8010

RE: Proposed HHS Notice of Benefit and Payment Parameters for 2018

Dear Acting Administrator Slavitt:

The National Association of Community Health Centers, Inc. (NACHC) is pleased to submit the following comments in response to CMS-9934-P, the Notice of Benefit and Payment Parameters for 2018. NACHC is the national membership organization for federally qualified health centers (FQHCs or "health centers"). 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 the attachment.

Health centers serve a critical role in the success of the Marketplaces in every state. They serve 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 eligible for Marketplace coverage, including Advanced Premium Tax Credits (APTCs) 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.

NACHC welcomes the opportunity to comment on the 2018 Notice of Benefit and Payment Parameters and will focus our comments on those areas of utmost importance to FQHCs.

Summary of NACHC's Comments

Network Adequacy:

- NACHC supports CMS' pilot testing of measures to indicate network breadth, and looks forward to the expansion of this pilot in future years.
- NACHC is disappointed that CMS has not used this Notice to strengthen network adequacy standards in Marketplace plans.

Essential Community Providers:

- Consistent with statutory requirements in the Affordable Care Act (ACA), CMS should institute an "any willing provider" requirement for QHPs to contract with ECPs.
- While CMS continues to develop the methodology to credit issuers for multiple providers at a single location, CMS state should explicitly in the Final Rule that QHPs may not contract directly with individual providers working within an ECP and they must contract with the ECP as an entity.
- At a minimum, CMS should require QHPs to offer legally-compliant, good-faith contracts to all FQHCs in their service area.
- CMS should state in regulatory language that all state-based Exchanges must adhere to standards around ECP contracting that are at least as strong as the Federal standards.

Consumer Assistance Tools and Programs of an Exchange:

- NACHC strongly urges CMS to maintain the requirement that taglines must be provided in the top 15 languages by state and not by an aggregated measure across states**.**

Details of NACHC's Comments

Network Adequacy

NACHC supports CMS' pilot efforts to test network breadth via a pilot program and believes that if proven successful, this pilot should be expanded in future years.

However, NACHC is concerned that CMS did not propose to strengthen the network adequacy standards for Marketplace plans in the proposed rule. Without stricter requirements, many QHPs fail to offer truly accessible plans, undermining the intent of the Marketplace, to ensure access to affordable health care. Given this concern, NACHC strongly encourages CMS to strengthen minimum Federal standards applied to FFE plans, either through regulation or the annual Letter to Issuers. As NACHC has commented on previous "Payment Notices," we suggest that CMS include the following measures and indicators and in future standards to ensure appropriate access:

- 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 specific standards 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.

Essential Community Providers (ECP)

- NACHC has long advocated for CMS to enforce the statutory provision that 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, this language clearly requires QHP issuers to offer-good faith contracts to all ECPs (as defined in the statute) located in their service areas. For this reason, we repeat our request that CMS enforce an "any willing provider" requirement for QHP contracting with ECPs, in all types of Marketplaces, as is stated in the ACA.
- CMS states in its proposed rule that it is developing a methodology to credit issuers for multiple providers at a single location for purposes of meeting the ECP requirement. NACHC supports CMS' efforts to develop such a methodology. In addition, we strongly encourage CMS to state explicitly in the Final Rules for 2018 and future years 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.
- 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.

Consumer Assistance Tools and Programs of an Exchange

- NACHC appreciates CMS' continued support for language access provisions, including requiring sample taglines in the top 15 languages spoken by the population in each state. However, we share the concern from the Association of Asian Pacific Community Health Organizations (AAPCHO) about the provisions of this proposed rule that could have the unintended consequence of removing needed taglines in common languages in states and communities across the country. Current policy says that the top 15 languages spoken by LEP individuals may be determined by aggregating the top 15 languages spoken by all LEP individuals among the total population of **each state**. This provision should be the minimum requirement for providing taglines and information for LEP populations. However, the proposed rule proposes clarifications that weaken these standards and allow Exchanges, issuers and web-brokers who operate in multiple States to aggregate the 15 top languages across all the states they serve—rather than on a state-by-state basis. This decision means that some prevalent languages in some states may not be reflected and the aggregated languages would not reflect the unique state-by-state populations. This aggregation reduces the availability of tag lines for groups that have a large presence in certain states but when states are aggregated, their language needs do not rise to the top 15 languages.

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In closing, NACHC appreciates the opportunity to submit comments on this Request for Information. NACHC and our member health centers would be happy to provide any further information that would be helpful.

Sincerely,

Colleen P. Meiman, MPPA
Director, Regulatory Affairs
National Association of Community Health Centers
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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 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 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 2014, on average, the insurance status of Health Center patients is as follows:

- 47% are Medicaid recipients
- 28% are uninsured
- 16% 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.