



January 30, 2023

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

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

The National Association of Community Health Centers (NACHC) is the national membership organization for federally qualified health centers (also known as FQHCs or health centers). Health centers are federally-funded or federally-supported nonprofit, community-directed provider clinics that serve as the health home for over 30 million people, including 1 in 5 Medicaid beneficiaries and over 3 million elderly patients. It is the collective mission and mandate of over 1,400 health centers around the country to provide access to high-quality, cost-effective primary and preventative medical care as well as dental, behavioral health, and pharmacy services and other “enabling” or support services that facilitate access to care to individuals and families located in medically underserved areas, regardless of insurance status or ability to pay.

Health centers serve a critical role in the success of Marketplaces in every state. They serve as the medical home for millions of Americans who are eligible for reduced-cost coverage through Federal and State marketplaces. Twenty-one percent of health center patients have private insurance and 46% of health center patients have Medicaid coverage, some of whom receive coverage through Medicaid expansion.<sup>1</sup> 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 helped nearly 4 million individuals seeking coverage in 2021.<sup>2</sup> This assistance includes helping individuals enroll in Medicaid, CHIP, Medicare, or the Marketplace; it also includes assisting individuals with re-enrollments, renewals, or redeterminations, as well as understanding and utilizing their newly acquired insurance. NACHC strongly appreciates that many of these proposed changes, especially related to outreach and enrollment and Marketplace protections, build upon the Administration’s proposed changes in the

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<sup>1</sup> <https://www.nachc.org/wp-content/uploads/2022/03/Chartbook-Final-2022-Version-2.pdf>

<sup>2</sup> <https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=ODE&year=2021>

proposed rule “Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes.”

NACHC welcomes the opportunity to comment on the 2024 Notice of Benefit and Payment Parameters and will focus our comments on those areas most important to FQHCs. Our comments are broken into four sections: I. Enhancing Network Adequacy Through Essential Community Providers; II. Reducing Barriers to Enrollment and Financial Assistance; and III. Cuts to User Fees and IV. Increasing Health Insurance Enrollee Protections.

## **I. Enhancing Network Adequacy Through Essential Community Providers**

**NACHC supports CMS’ proposal at § 156.235 to increase the percentage of FQHCs Qualified Health Plans (QHP) issuers are required to contract with from 30% to 35%.** FQHCs are the largest single source of primary care in medically underserved areas and for medically underserved populations. They provide all the necessary health services to help ensure their patients can live healthier lives and increase their overall well-being. Congress designed the Essential Community Providers (ECP) provision of the Affordable Care Act (ACA)<sup>3</sup> to ensure that consumers purchasing coverage on the Marketplace have guaranteed access to trusted providers, which include entities such as community health centers, HIV/AIDS clinics, and family planning health centers. When expansions in health insurance coverage are matched with strong network adequacy protections, patients have more coverage options that connect them with comprehensive, accessible, and qualified community providers to meet their medical needs.

It is important that the Department proactively monitor and enforce QHP compliance with the federal ECP standard and partner with state-based Marketplaces to ensure that plans, including managed care plans, across the nation meet the ECP participation standard. Stronger oversight and enforcement will ensure that families will have adequate access to affordable, quality care provided by health centers, located within their own communities. NACHC recommends CMS revise the Managed Care reporting template to include more detail on what types of ECPs Managed Care issuers contract with, to ensure that they are indeed contracting with at least 35% of ECPs, and FQHCs, in their service area.

**Additionally, to ensure that insurers are contracting with FQHCs, NACHC recommends CMS enforce the “any willing provider” statutory provision for QHPs to contract with ECPs.** Section 1311 of the ACA states that QHPs “shall... include within health insurance plan networks 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. NACHC recommends CMS enforce this requirement given the statutory language. Currently, CMS mandates that QHPs on FFMs must “offer contracts in good

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<sup>3</sup> Section 1311(c)(1)(C)

faith to at least one ECP in each ECP category in each county in the service area to participate in the plan's provider network for the respective QHP certification plan year, where an ECP in that category is available..."<sup>4</sup> but given the crucial role health centers play in delivering primary care services, NACHC believes that these good-faith contracts should extend to all FQHCs in their service area.

**NACHC recommends CMS enforce this statutory provision of good-faith contracts, which will better ensure FQHCs are being reimbursed at least their PPS rate for QHPs, as well as managed care plans.** QHPs are required to pay health centers their Medicaid PPS rate<sup>5</sup> unless they have agreed on an in-network, contracted payment rate, which may or may not be equal to the Medicaid rate. For the purposes of Medicaid, this is a comprehensive, bundled, per-visit rate based on the historical costs of Medicaid services in 1999 and 2000. Receiving PPS is central to the successful relationship between FQHCs and their patients and to health centers continued financial viability. Currently, there is no official tracking mechanism for stakeholders, like NACHC, to engage with states and hold them accountable. NACHC recommends CMS create a tracking system to ensure FQHCs are being reimbursed properly with by the QHPs or managed care plans they contract with.

Notably, Essential Community Providers are also cited as "those who serve predominantly low-income, medically underserved individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service Act and described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act,"<sup>6</sup> part of the 340B statute, which grants covered entities access to the 340B Drug Pricing Program. The 340B program allows covered entities to provide more accessible pharmacy services and reasonably priced medications to their patients, because they serve a disproportionate number of lower-income patients. The inclusion of the ECP provision within the 340B statute shows how essential community providers, like FQHCs, are inextricably tied and rely heavily on the benefits of the 340B program. Under the same operating statute, the 340B program and ECP requirements share the same goal: to provide safety net providers with the resources they need to serve the most vulnerable and medically underserved communities. Health centers use their savings through the 340B program to meet the unique needs of health center communities with services such as dental care, behavioral health, specialty care, translation services, food pantries, and housing support. Health centers greatly benefit by participating in a stable 340B program to provide services and resources not funded by reimbursement or non-revenue generating services. It is important for federal agencies, including CMS, understand the implications of the current 340B attacks and the ability for essential community providers like FQHCs to serve Medicaid, Medicare, and Marketplace patients.

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<sup>4</sup> <https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>

<sup>5</sup> Section 1902(bb) of the Social Security Act

<sup>6</sup> <https://www.cms.gov/files/document/ecp-listing-cover-sheet-03262013pdf#:~:text=Under%20that%20regulation%2C%20essential%20community,of%20the%20Social%20Security%20Act.>

## II. Reducing Barriers to Enrollment and Financial Assistance

**NACHC strongly supports the proposed changes—repealing § 155.210(d)(8) and § 155.225(g)(5)— to allow navigators and certified assistant counselors to go door-to-door and provide enrollment assistance.** Health centers leverage their trusted relationships in their communities and do the additional work as ECPs to ensure their patients understand health insurance and get enrolled in the most comprehensive services. Under the health center program, every patient completes a financial assessment to determine if they are eligible for sliding fee discounts and health insurance coverage. Health centers employ dedicated staff, such as health navigators, community health workers, and assisters, who help consumers understand and enroll in health insurance coverage options. NACHC appreciates the Administration for their continued investment in navigators and enrollment assisters as these resources have played an integral role coming out of the COVID-19 pandemic.

Navigators being able to travel to an enrollee’s residence enhances the opportunity to get more people enrolled in health insurance coverage. This proposed provision will allow navigators and other types of assisters to better meet patients where they are, hopefully allowing more people to receive health coverage. Health center patients are more likely to experience SDOH that can negatively impact their ability to seek health coverage, especially in person. Impacts such as lacking access to reliable, affordable transportation or having a chronic condition or a disability could impact being able to seek help getting health insurance in-person. Other health center patients may lack adequate broadband access to apply for insurance online or live in rural area where it can be difficult to solicit enrollment assistance. NACHC appreciates CMS creating more flexibility for navigators and certified assistance counselors to go into the community and reach the patients who need the most support.

**NACHC also supports the proposal at §155.335 to allow Exchanges to directly re-enroll CSR-eligible enrollees into QHP silver plan from a bronze plan under the same product and QHP issuer.** These types of changes allow enrollees to have more comprehensive coverage with potentially fewer out-of-pocket costs without having to spend more money on a monthly premium. On average, health care spending per person was \$12,914 per person in 2021.<sup>7</sup> With the median U.S. household income reported at \$70,784 in 2021,<sup>8</sup> that is a large percentage of a person’s take-home pay. Instead of spending a significant amount of their income on out-of-pocket costs working towards meeting a high-deductible bronze plan, enrollees can put that money towards food, housing, or improving their quality of life and not avoid care due being underinsured. Finalizing

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<sup>7</sup> <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=U.S.%20health%20care%20spending%20grew,trillion%20or%20%2412%2C530%20per%20person>.

<sup>8</sup> <https://www.census.gov/library/publications/2022/demo/p60-276.html#:~:text=Highlights,and%20Table%20A%2D1>).

this proposed change will positively impact people by easily granting them better, more comprehensive coverage without costing them extra money.

**NACHC also appreciates CMS’ proposal under § 155.420(d)(1) to give Exchanges the option to implement a new special rule for consumers eligible for a Special Enrollment Period – allowing consumers up to 60 days before their loss of insurance or 90 days after their loss of insurance, to select a plan under the Exchange.** Before the continuous coverage provision implemented during the pandemic, 1 in 10 Medicaid/CHIP beneficiaries experienced churn in less than one year.<sup>9</sup> This can be attributed to lost paperwork, administrative error, or a change in address. Furthermore, while states are doing all they can to prepare for redeterminations, inevitably some notices to enrollees could not make it to enrollees and result in loss of coverage. Ensuring that enrollees have an adequate amount of time to obtain insurance on the Marketplace in the event they no longer qualify for Medicaid/CHIP is crucial. Maintenance of insurance coverage contributes to continuity of care, which helps ensure healthier outcomes for health center patients.

### **III. Cuts to User Fees**

NACHC appreciates the Administration’s continued investment in the outreach and enrollment workforce, especially CMS awarding health centers \$80 million for 60 navigator programs for the 2022 plan year in 30 states with a Federally-Facilitated Marketplace.<sup>10</sup> Funding for this workforce is so important for health centers and the patients we serve. While outreach and enrollment services are built in the 330 grant that health centers receive, O/E work is not covered as “billable providers” and reimbursable services, making the continued funding from the Administration crucial so that health centers can reach more patients. This funding has also provided health centers the necessary resources to assist with upcoming needs related to Medicaid redeterminations. Because states will be able to start Medicaid redeterminations April 1, there are an estimated 5 to 14 million people who could lose Medicaid coverage, likely making them eligible for coverage on the Marketplace.<sup>11</sup>

**NACHC is concerned that the timing of user fee cuts and the high volume of Medicaid redeterminations can have a negative impact on the workforce and resources required to mitigate the unnecessary churn of consumers.** The marketplace user fee — a fixed percentage of premium revenue paid by insurers — supports critical functions, including the operation and improvement of the HealthCare.gov website, the Marketplace call center, the Navigator program, consumer outreach, and advertising. The HealthCare.gov website, the Marketplace call center, and these consumer-facing functions are critical for health centers across the country because they

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<sup>9</sup> <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/>.

<sup>10</sup> <https://www.hhs.gov/about/news/2021/08/27/biden-harris-administration-quadruples-number-health-care-navigators-ahead-healthcare-open-enrollment-period.html>

<sup>11</sup> <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/>

ultimately impact patient outcomes; more funding leads to a strengthened outreach and enrollment workforce providing services that help increase enrollment in health insurance.

Health centers have utilized marketing and outreach funding under the ACA by incorporating Community Health Workers (CHWs) into their patient care teams. CHWs and enrollment assisters are public health workers who are trusted members of, or are closely connected to, a community. They provide unbiased enrollment assistance and facilitate access to services which improve the quality of care for patients. Unlike CHWs and enrollment assisters funded by the user fees, private navigators and assisters are oftentimes paid commissions by a third party. This third-party creates incentives for private navigators and assisters to direct consumers to certain private products, rather than promoting consumer utilization in a neutral manner. Given that these core marketplace functions are funded by user fees, CMS' proposed changes may create unintended consequences and make it more difficult for consumers to access accurate and comprehensive eligibility information for Medicaid and related programs associated with HealthCare.gov.

While we understand the intent that lower user fees may decrease health care premiums, the reduction in funding will ultimately have a negative impact on the services that connect patients to health insurance coverage. For example, from 2016 to 2019, when outreach and enrollment experienced significant budget cuts, unsubsidized enrollment decreased by 2.8 million people.<sup>12</sup> While those were significant cuts, a cut to funding at a crucial time of redeterminations may negatively impact redetermination efforts. Although these user fees do not go into effect until 2024, states have 12 months to initiate redeterminations and 14 months to fully complete redeterminations;<sup>13</sup> this means States will be continuing to complete these determinations into 2024. These Federally-Facilitated Marketplaces and State-Based Marketplaces will need the financial support for enrollment, which is funded in part by these user fees.

**Rather than cutting the user fee, NACHC recommends they remain at their current percentages: 2.5% in the marketplace and 2.25% in the state-based marketplace.** NACHC also advocates strongly for CMS to invest more in outreach and enrollment services in general. If there was more federal funding that supported outreach and enrollment services, health centers and other community providers would not rely as much as user fees. In particular, the outreach capabilities would assist health centers in continuing to employ neutral navigators who provide accurate, unbiased information. Further investment in enrollment assistance programs would reduce burden on the safety net and generally ensure better public health, because having health

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<sup>12</sup> <https://www.cms.gov/newsroom/press-releases/unsubsidized-enrollment-individual-market-dropped-45-percent-2016-2019-0>

<sup>13</sup> [Key Dates Related to the Medicaid Continuous Enrollment Condition](#)

insurance is associated with increased access to health services and better health monitoring.<sup>14</sup> <sup>15</sup> States need to be offered additional funding in order to keep up with the anticipated large number of Medicaid redeterminations, as stated earlier. Health centers will play a crucial role in helping enrollees understand their new coverage and adequate funding will help bolster the workforce during this time.

#### **IV. Increasing Health Insurance Enrollee Protections**

**NACHC supports CMS’ proposal to amend §155.220(j)(2)(ii) to require web brokers submit additional documentation when submitting their health insurance application.** By requiring documentation confirming that all enrollment application has been reviewed by and confirmed as accurate by the consumer or their authorized representation before application submission, this will protect consumers’ interests as they choose insurance on the Marketplace. Given that brokers and agents are commission-based, unlike Navigators who are trained to provide unbiased opinions, this could pose a problem for enrollees especially given that these interactions are oftentimes web-based. While no report states the exact number of instances where web brokers sign enrollees up for different coverage than promised or without their consent,<sup>17</sup> there have been reports of people discovering they obtained Marketplace coverage without their knowledge. For example, a 2015 case found that web brokers were signing up people experiencing homelessness and putting down questionable incomes for the enrollees, allowing them to receive zero-premium plans.<sup>18</sup> While many health center patients seek out enrollment assistance from health center outreach and enrollment staff, adding these protections will enhance the integrity of web-brokers and protect enrollees, like health center patients, who choose to use their services.

**NACHC supports the first CMS proposal in § 156.202 to limit the number of non-standardized plan options that QHP issuers may offer through the Federal Exchanges to two non-standardized plan options per product network type and metal level (excluding catastrophic).** When seeking health insurance coverage, it can be confusing and overwhelming for individuals to understand and ultimately choose from all the different plan options presented on the Exchange. For instance, in 2019, the number of plans shown to the average marketplace consumer has grown from 25.9 to 113.6 in 2023.<sup>19</sup> While the majority of Marketplace plans are

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<sup>14</sup> Baicker, K., Taubman, S. L., Allen, H. L., Bernstein, M., Gruber, J. H., Newhouse, J. P., ... & Finkelstein, A. N. (2013). The Oregon experiment — effects of Medicaid on clinical outcomes. *New England Journal of Medicine*, 368(18), 1713–1722.

<sup>15</sup> McWilliams, J. M., Zaslavsky, A. M., Meara, E., & Ayanian, J. Z. (2003). Impact of Medicare coverage on basic clinical services for previously uninsured adults. *JAMA*, 290(6), 757–764.

<sup>16</sup> Buchmueller, T. C., Grumbach, K., Kronick, R., & Kahn, J. G. (2005). Book review: The effect of health insurance on medical care utilization and implications for insurance expansion: A review of the literature. *Medical Care Research and Review*, 62(1), 3–30.

<sup>17</sup> <https://www.npr.org/sections/health-shots/2022/01/17/1073282236/some-insurance-brokers-enroll-people-in-aca-plans-without-consent>

<sup>18</sup> <https://khn.org/news/aetna-breaks-ties-to-man-who-sold-policies-to-hundreds-of-homeless/>

<sup>19</sup> <https://www.shvs.org/the-proposed-2024-notice-of-benefit-payment-parameters-implications-for-states/>



standardized, this change will help streamline and overall simplify the selection process for enrollees. It will also help simplify the process for any assisters or navigators who are helping consumers browse their options.

**Similarly, NACHC applauds CMS for its proposal to revise § 156.201 to require insurers to place covered drugs in the appropriate formulary tier, and NACHC also agrees that four tiers in a plans' drug formulary is sufficient.** This will help patients when shopping for plans by keeping a standardized, more simplified system so they can more easily compare coverage options. It is important that individuals thoroughly understand their prescription drug coverage, given that even with the help of insurance, patients still struggle to afford the medication they need. Health centers provide their patients with affordable, accessible medications and other pharmacy services, in-house and/or contracting with pharmacies directly in their patients' community. Because of the 340B program, health centers can offer services such as copayment assistance programs to help lower the financial barrier patients may face when getting prescriptions. NACHC appreciates CMS' intent to ensure patients can more easily determine which plan is right for them so patients can access the drugs they need through health centers or other providers.

**NACHC also supports § 156.270(f), which adds a timeliness standard by requiring issuers to send notices of late payment promptly and without undue delay;** this will help better ensure consumers' continuity of coverage and assure access to health care services. NACHC appreciates CMS recognizing how administrative functions can impact continuity of coverage and supports the proposal to add timeliness standards in sending late payment notices. If an enrollee is unaware of their late payment due to lack of sufficient correspondence, this protection will help protect enrollees and ensure their insurance is not unfairly terminated. Health center patients are lower-income and experience more social determinants of health that could impact their ability to make timely payments. Factors like unstable housing or lack of reliable broadband access could negatively impact a patient's ability to either pay on time or receive notice about a late payment. Getting that notice to enrollees expediently, and by utilizing different methods of contact, will increase the chances of receiving notice and decrease the chance of their health insurance being revoked.

NACHC recommends insurers send notice of payment immediately after the deadline, using the enrollees' preferred methods of contact, and embed the delinquency notice within future payment reminders to help mitigate the chance that one outstanding bill could trigger total insurance loss. Ensuring enrollees are notified multiple times, using multiple contact methods, is in line with proposals outlined in the Administration's proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

**Another enrollee protection NACHC supports is the Administration's proposal (§ 155.305(f)) to not deny an enrollee APTC based on IRS data that a consumer failed to pay their previous year's APTC, unless the enrollee has failed to do so in the past two years.**



Especially given the backlog experienced at the IRS and many other governmental agencies during the pandemic, this slight administrative change lends heightened protection to more financially vulnerable enrollees who are supposed to qualify for APTCs. Furthermore, as cited in the proposed rule, Exchanges still face operational challenges and enrollees should not be financially penalized in the case of an unintentional technical issue within the Exchange. Over 20% of health center patients have private insurance coverage and this change will positively promote continuity of coverage for them.

The provisions in this proposed rule will positively impact health center patients' access to quality, affordable health coverage and care through enhanced access to services, simplifying plan choice and the selection process, and easing enrollment in coverage. We greatly appreciate the opportunity to provide comment on this proposed rule. Should you have any questions about our comments, please feel free to contact Vacheria Keys, Director of Regulatory Affairs, at [vkeys@nachc.org](mailto:vkeys@nachc.org).

Sincerely,

A handwritten signature in black ink that reads "Joe Dunn". The signature is written in a cursive, flowing style.

Joe Dunn

Senior Vice President, Public Policy and Research

National Association of Community Health Centers