



American
Public Health
Association



NACCHO

National Association of County & City Health Officials

The National Connection for Local Public Health



October 28, 2011

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

RE: Comments on Proposed Rule, Establishment of Exchanges and Qualified Health Plans (RIN 0938-AQ67)

To Whom It May Concern:

We are appreciative of the Centers for Medicare and Medicaid Services (CMS) for the opportunity to offer comments on the proposed rule establishing Exchanges and Qualified Health Plans (QHPs).

As organizations dedicated to disease prevention and promoting public health, those who represent public health officials and practitioners, and others, we would like to indicate our support for the efforts, including this proposed rule, that are being undertaken to establish health insurance Exchanges. As you know, Exchanges represent a critical opportunity to expand insurance coverage to millions of new Americans and thus an important step in our nation's efforts to place a new emphasis on prevention and wellness.

The National Prevention Strategy, released this past June by the Department of Health and Human Services (HHS) and 16 other federal agencies, identifies four distinct yet related strategic directions towards our ultimate goal of increasing the number of Americans who are healthy at every stage of life. One of the four strategic directions is ensuring "that prevention-focused health care and community prevention efforts are available, integrated, and mutually reinforcing."¹

Qualified health plans and Exchanges can serve as a vital tool in pursuing this strategic direction by helping to link individuals to clinical and community preventive services and reimburse appropriately when they are utilized. We would therefore like to suggest

¹ The National Prevention Strategy: America's Plan for Better Health and Wellness, June 2011.

several areas of the proposed rule that should be strengthened to ensure that we maximize this opportunity to pursue and achieve our national prevention and wellness goals.

Exchange Governing Board Structure, §155.110(c)

We applaud the federal requirement that Exchange governing boards have a majority of members with relevant experience in health benefits administration, which the rule notes includes both health care delivery system administration and public health (subsection 4). We had previously noted in earlier comments that state and local public health departments as well as community-based public health organizations should be considered key stakeholders in current activities aimed at promoting the use of and delivering both clinical and community preventive services.

The proposed rule however, does not make clear whether Exchange governing boards must include at least one representative with relevant experience in public health. We ask that the final rule clarify that, in addition to the majority requirement, that Exchange governing boards must also include at least one representative with public health experience or expertise. Doing so would ensure that the state's public health community is actively involved in Exchange operations and able to leverage partnerships and networks to support prevention and health promotion efforts.

Stakeholder consultation §155.130

We are also pleased to see that both “public health experts” (subsection g) and “health care providers” (subsection h) were included in the list of stakeholders that Exchanges must regularly consult for input and expertise. The inclusion of public health officials, including state and local health departments, within the consultation process helps to ensure that public health agencies and partners are able to engage and participate in the Exchange process. We agree that including these and other groups “will provide diverse input and will be informative of the viewpoints of the various groups impacted by the Exchange.”

Navigator functions §155.210

The proposed rule notes that CMS seeks specific comment on whether Exchanges should be required to award at least one Navigator contract to a community and consumer-focused not-for-profit or whether Navigator grantees should instead represent a variety of identified types of entities.

We respectfully offer that while there is merit to both approaches, the former is more likely to achieve what should be a primary goal for Navigators – reaching underserved and relatively hard-to-reach populations about the availability, benefits, and enrollment process for Qualified Health Plans within the Exchange. Therefore, we recommend that Exchanges be required to award at least one Navigator contract to a community or consumer-focused not-for-profit.

We also respectfully note that like community-based organizations, state and local public health departments have a demonstrated track record in serving and communicating with the uninsured population and should already possess the capacity to fulfill the many duties of the Navigator program (as outlined in subsection d).

We thus recommend that state and local health departments be listed as an eligible recipient of Navigator grants.

Consumer assistance tools and programs §155.205

We support the inclusion of section 155.205 of the proposed rule and notes that consumer assistance tools and outreach will be a critical component of ensuring that Exchanges are able to help, facilitate enrollment for, and address concerns from members of vulnerable populations. In the preamble discussions of proposed subsection (e), it is noted that Exchanges should be encouraged “to target specific groups including hard to reach populations and populations that experience health disparities due to low literacy, race, color, national origin, or disability, including mental illnesses and substance use disorders.”

However, the proposed rule itself requires only that an “Exchange must conduct outreach and education activities to educate consumers about the Exchange and to encourage participation.” We respectfully request that this requirement be strengthened within the rule itself to reflect the sentiment in the preamble and make explicit reference to targeting specific groups, particularly those that represent hard to reach populations or those that experience health disparities.

Network Adequacy and essential community providers §156.230 and 156.235

We agree with your decision to codify section 1311(c)(1)(C) of the Patient Protection and Affordable Care Act (ACA) and agree that provider networks established as part of a QHP must include essential community providers to ensure that individuals can access and afford to receive clinical services, including outside the traditional physician office setting. This includes community health centers, state and local public health departments, Ryan White Care providers, and many others.

Section 1311(c)(1)(B) of the ACA is a network adequacy requirement for qualified health plans; section 1311(c)(1)(C) is meant to offer an additional set of protections for plan enrollees to ensure that they have access to a robust set of services from a specific set of essential community providers. We believe that the proposed rule as drafted supports this concept but additional language within the preamble or explanation of a final rule could help clarify this further.

We also recognize the potential difficulty of reconciling the essential community provider requirements of the Affordable Care Act (ACA) with an ACA requirement that a QHP must reimburse Federally Qualified Health Centers (FQHCs) at an amount no less than the Medicaid prospective payment system (PPS) rate. TFAH notes that both of

these requirements though, are reaching towards a similar goal – ensuring that individuals, particularly those who are low-income or traditionally underserved, who are enrolled in QHPs via new Exchanges have adequate access to clinical care services.

We therefore recommend that QHP issuers be required to contract with essential community providers on an any-willing provider basis. This would seem to satisfy the statutory requirement that essential community providers be included “where available.” Furthermore, while the preamble to the proposed rule notes that there are some concerns about such a requirement on the ability of QHPs to use tiered network structure to promote higher quality services, we respectfully note that 340(B) providers, including FQHCs and others, and health departments, are all relatively “known entities” that are already regulated by federal and state requirements.

We also note with respect to FQHCs that a reimbursement “work-around” strategy may be required to ensure that QHPs that enroll a disproportionately high number of beneficiaries that receive services at FQHCs are not unfairly penalized by the requirement to adhere to Medicaid payment rates for these services. There are multiple risk-adjustment or reinsurance strategies that could be pursued to protect QHP risk against this scenario. We would refer you to comments submitted by the National Association of Community Health Centers and would look forward to helping you and the States work to address this issue.

We also recommend that the definition of essential community providers be modified to include health departments that provide covered services, which today are critical to providing health screening and monitoring services and many other similar services as those provided by the types of organizations that are recognized in section 340B(a)(4) of the Public Health Service Act. By establishing a definition of essential community providers that is limited to only those organizations that are explicitly listed in section 340B(a)(4), Exchanges could miss a critical opportunity to ensure that health department and public health activity are integrated more closely with patient and individual medical services.

Thank you for the opportunity to comment on this important proposed rule. We look forward to working with you as the final rule is developed and implementation of Exchanges and Qualified Health Plans continues. If you have any questions, please feel free to contact Becky Salay, Government Relations Representative for Trust for America’s Health, at 202-223-9870 x 15 or at bsalay@tfah.org.

Sincerely,

American Public Health Association
Association of State and Territorial Health Officials
National Association of County and City Health Officials
Trust for America’s Health