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Requirements for Group Health Plans and Health Insurance Issuers:

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General Comment

See attached file(s)

Attachments

IRS-2010-0021-0017.1: Comment on FR Doc # 2010-18050

CHCANYS | *Defining New Directions*

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
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The Community Health Center Association of New York State (CHCANYS) is pleased to respond to the above-cited request for comments from the Department of Health and Human Services, Office of Consumer Information and Insurance Oversight. Our comments echo those submitted on behalf of the National Association of Community Health Centers (NACHC), which we support.

Background

CHCANYS is a non-profit association of community health centers throughout New York State. CHCANYS represents over sixty community health centers that provide high-quality and affordable care at over 457 sites. From advocating for funding for innovative programs to educating community health centers on the latest health information technology, CHCANYS works tirelessly to provide community health centers with the resources they need to provide high-quality, community-based primary care.

Community health centers are an essential element of New York State's network of providers. From the hills of the Adirondacks to the streets of the Bronx, community health centers have become the "family doctor" for 1.4 million patients living in medically underserved communities throughout New York. Eighty-six percent of New York's health center patients have incomes at or below 200% of the federal poverty level; forty-one percent are Medicaid beneficiaries. Seventy-two percent of health center patients in New York are minorities, while twenty-three percent are best served in a language other than English. Most importantly, community health centers provide this diverse patient population with high-quality, yet affordable care. Indeed, community health centers typically spend thirty percent less than the average spending on patients treated by other providers while improving outcomes.

The extraordinary work of community health centers is not unique to New York. Since 1965, community health centers across the nation have delivered comprehensive health and social support services to people who otherwise would face major financial, social, cultural and language barriers to obtaining quality, affordable health care. More than 1,200 community-based health centers are in operation today. Collectively, these centers serve as a health care safety net for more than eighteen million people, thirty-nine percent of whom are uninsured, through 6,600 delivery sites in urban and rural underserved communities in all fifty states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands.[1]

Community health centers are integral to the success of health care reform. Under the Patient Protection and Affordable Care Act (PPACA), Congress established a Community Health Center Trust Fund to provide $9.5 billion for increasing health center capacity and services over the next five years.[2] Congress also appropriated an additional $1.5 billion for health center capital projects.[3] Through these allocations, Congress has signaled that community health centers' patient-centered, cost-effective, and high quality approach to care will be central to caring for millions of newly insured patients, as well as those who remain uninsured post-reform.

Given the importance of community health centers in the effort to provide high-quality, affordable care to all Americans, we respectfully request that the Department of Health and Human Services consider the comments detailed below.

Ensure Federally Qualified Health Centers Are Able To Contract With Qualified Health Plans and Are Reimbursed at the Medicaid PPS Rate

When defining the certification criteria for plans offered on a health insurance exchange, we encourage the Secretary to issue regulations clarifying the relationship between federally qualified health centers (FQHCs) and qualified health plans. Under PPACA, to be offered on a health insurance exchange, an insurance plan must be a "qualified health plan."[4] The Secretary of the Department of Health and Human Services must establish criteria for the certification of health plans as qualified health plans.[5]

PPACA includes FQHC-specific reimbursement requirements for qualified health plans that are designed to protect federal investments in FQHCs. Most community health centers receive federal grants under Section 330 of the Public Health Services Act (42 U.S.C. § 254b) to assist in covering the otherwise unreimbursed costs of comprehensive primary and preventive care and federally mandated enabling services to uninsured and underinsured patients, as well as to maintain the health center's infrastructure. In order to

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[1] Fact Sheet, America's Health Centers, National Association of Community Health Centers, *available at* http://www.nachc.org/client/documents/America's_Health_Centers_updated_8.13.083.pdf.
[2] PPACA § 10503(a)-(b).
[3] PPACA § 10503(c).
[4] PPACA § 1311.
[5] PPACA § 1311(c).

ensure these funds are available for this purpose, Congress has enacted special statutory protections that require state Medicaid programs to reimburse FQHCs for their approximate costs in serving Medicaid patients. This mandate is known as the Medicaid Prospective Payment System (PPS). 42 U.S.C. § 1396a(bb). Similar protections in the law ensure adequate payment for Medicare services to FQHCs. 42 U.S.C. §1395L(a)(3). And in 2009, Congress extended this protection further, requiring that reimbursement to FQHCs under the Children's Health Insurance Program (CHIP) be no less than that under the Medicaid PPS system. 42 U.S.C. § 1397gg(e)(1)(E).

PPACA extends this protection, once again, to reimbursement provided by qualified health plans participating in exchanges. Section 10104 of PPACA provides that for any service covered by a qualified health plan that is provided by a federally-qualified health center to an enrollee of that qualified health plan, the qualified health plan must pay the health center no less than what would have been paid under Medicaid PPS. This protection is unique to FQHCs. Through this protection, Congress has ensured that federal 330 funds are not diverted from their purpose of providing care for the uninsured and underinsured to supplementing otherwise potentially inadequate reimbursement of private plans participating in the health insurance exchange.

PPACA also requires that all plans offered on the exchanges include providers like community health centers in their networks. Although Congress has afforded the Secretary broad discretion in establishing the certification criteria, Congress has specified that, at minimum, to be certified as a qualified health plan, a plan must:

> 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 . . . .
>
> PPACA, § 1311(c)(1)(C). Federally-qualified health centers are first among those providers defined in section 340B(a)(4) of the Public Health Service Act, 42 U.S.C. § 256b(a)(4).

PPACA goes on to qualify this mandate, providing that it does not require a qualified health plan to contract with a provider that "refuses to accept the generally applicable payment rates of such plan." PPACA § 1311(c)(2). While this provision allows a plan to avoid contracting with some essential community providers (those refusing to accept generally applicable rates), when read together with the reimbursement mandate for FQHCs articulated in Section 10104, it cannot and does not do so for FQHCs. Of the providers listed in Section 340B(a)(4) for the Public Health Service Act, only FQHCs received express reimbursement protection in PPACA. When taken together, the clear meaning of these provisions is that for services provided by FQHCs, section 10104 sets the "generally applicable payment rates" for a plan at the Medicaid rate. A plan, then, may set the generally applicable payment rate it offers other types of providers serving predominantly low-income individuals in medically underserved communities, but

Congress, through Section 10104 of PPACA, has set the generally applicable payment rate a plan must offer to FQHCs as the Medicaid PPS rate.

In promulgating regulations implementing the provisions described above, we urge that the Secretary clarify three matters. First, the Secretary should clearly pronounce that there will be payment parity for providers across Medicaid and qualified health plans. Second, the Secretary should clarify that qualified health plans may not decline to include community health centers in their provider networks simply because the health centers demand to be reimbursed at the statutorily mandated Medicaid rate. Finally, the Secretary should make clear that qualified health plans are required to contract with any FQHC that is willing to join the plan's network.

Without such clarification qualified health plans could seek to exclude community health centers from their provider networks simply for seeking reimbursement rates mandated under the law. With numerous provisions to support the growth of primary care, generally,[6] and community health centers, specifically,[7] PPACA clearly intends that community health centers will be an integral part of America's post-reform health care system. Allowing qualified health plans to avoid contracting with qualified health centers would circumvent the intent and clear meaning of the legislative language, jeopardize the financial health of community health centers, and undermine their role in providing high-quality care to millions of newly insured and the remaining uninsured patients across the country. Clarifying that PPACA requires that qualified health plans contract with any willing FQHC, as we urge the Secretary to do, is consistent with the clear language and overall intent of the statute.

Promote Enrollment Through Seamless, Consumer-Friendly Eligibility Systems and Processes

In New York, as nationally, a substantial percentage of those currently uninsured are eligible today for public health insurance.[8] These individuals would be covered by public health insurance, but for the fact that they have not yet enrolled. High barriers to enrollment, such as complicated paperwork or long delays, deter potential enrollees from obtaining the insurance to which they are entitled. Not only do these individuals not receive health insurance coverage that they deserve, but the providers that care for them are not reimbursed for their services, further straining the health care safety net.

PPACA includes several provisions targeted to ensure enrollment processes for individuals eligible for public insurance subsidies – whether through Medicaid, CHIP or the exchange – are seamless, including a single, streamlined application and coordinated

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[6] *E.g.*, PPACA § 1202 (increasing Medicaid payments for primary care services); PPACA § 5301 (funding primary care training programs); PPACA § 5405 (establishing the Primary Care Extension Program).
[7] PPACA § 10503(a)-(c).
[8] NYS Health Foundation, *Implementing Federal Health Care Reform: A Roadmap for New York State*, 4 (2010), *available at* http://www.nyshealthfoundation.org/content/document/detail/12482/ (estimating that 42% of those uninsured in New York State are eligible for Medicaid but not enrolled).

eligibility procedures.[9] The Secretary should make clear that PPACA requires "no wrong door" enrollment system for all forms of insurance, whether offered through the exchanges, Medicaid, or CHIP, and that that system must be consumer-friendly, accessible, and must avoid unnecessary and burdensome application requirements. Further, states must receive adequate support to build and upgrade the eligibility systems currently in place for public programs. In New York, eligibility systems for public programs are rooted in antiquated information technology, creating substantial barriers to innovation and integration with the exchange. By requiring and supporting consumer-friendly, fully integrated enrollment systems across Medicaid, CHIP, and commercial insurance, the Secretary will ensure access to coverage, improve administrative efficiency, and reduce the burdens of uncompensated care.

Community Health Centers Have a Role in Helping Patients Navigate Coverage

Just as community health centers are a critical source of primary care services for consumers purchasing insurance on the exchanges, community health centers will also be an important partner in promoting informed choice among consumers and facilitating enrollment in all forms of insurance. Indeed, New York's community health centers have extensive experience enrolling eligible patients in Medicaid and CHIP. As part of New York's facilitated enrollment program, community health centers assess whether applicants are eligible for public health insurance, assist them in completing their applications, and aid them in selecting a managed care plan. Community health centers also have long provided presumptive eligibility for pregnant women, and in recent years worked in partnership with the State to expand presumptive eligibility to children.

With exchanges providing another option for affordable insurance for consumers, New York's community health centers can build upon their prior experience enrolling individuals in public health insurance programs to help consumers navigate the expanding set of insurance options, including connecting to the appropriate subsidy or program and make informed choices form among plans. New York's facilitated enrollment program is a model for how community health centers and other community-based organizations can be a critical source of information and assistance so that consumers find the best coverage to suit their needs.

Ensure Federal Requirements of Services Under the Essential Health Benefits Serve as a Floor, Not a Ceiling, for States

PPACA specifies the essential health benefits that must be provided by qualified health plans in the exchange. To the extent that the Secretary provides more specific guidance on what services must be provided within each benefit identified within PPACA, it should do so only to set a floor, not a ceiling, for States. For example, the PPACA defines "ambulatory patient services" as an essential health benefit.[10] In New York, ambulatory patient services must include bone density measurements for group

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[9] See PPACA §§ 1413, 2201.
[10] PPACA § 1302(b)(1)(C).

commercial, HMOs and Article 43 insurers. New York should maintain the flexibility to determine whether such requirements should extend to the definition of ambulatory patient services provided by qualified health plans in the exchange. The Secretary should make clear that such coverage does not constitute an additional benefit beyond those essential health benefits required by the PPACA,[11] but instead simply provides greater specificity as to what services fall within a broad category of essential health benefits under the law.

Include Consumers and Community Health Centers in the Exchange Governance

The Secretary should ensure that the governing boards of the exchanges include providers, like community health centers, that primarily serve low-income patients in medically underserved communities. The needs of patient populations at community health centers differ somewhat from those seeking care at other providers, whether because patients at community health centers often need translation services or assisting coordinating benefits from various public programs. Community health centers have years of experience addressing the unique needs of this patient population. Furthermore, by law, at least fifty-one percent of members on the boards of federally-qualified health centers are consumers of the health centers' services, ensuring that the consumers' interests are well represented.[12] By including representatives from community health centers on the board of the exchanges, the Secretary can ensure that the needs of low-income and medically-underserved patients are represented.

Give Exchanges Strong Enforcement Authority

After ensuring that relevant stakeholders are included in the governing bodies of the exchanges, we urge the Secretary to give those boards meaningful powers. Specifically, we encourage the Secretary to make clear that the governing bodies of exchanges have strong enforcement authority to ensure continuing compliance with the certification criteria. Importantly, exchanges should have the authority to de-certify plans for failing to promptly make reimbursement payments or failing to maintain adequate primary care capacity.

Provide Clear Explanations of Plan Benefits To Promote Informed Choices by Consumers and Ensure Adequate Primary Care Capacity

Among the responsibilities of the exchanges is to provide standardized comparative information on qualified health plans. This information must clearly state all covered services, exclusions, and cost-sharing requirements, as well as a list of covered providers stating the hours, locations, and linguistic services of those providers, so that consumers can select the plan that best suits their needs.

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[11] Although states may require qualified health plans to provide additional benefits, PPACA § 1311(d)(3)(A), the states must assume any additional costs associated with these additional benefits, PPACA § 1311(d)(3)(B).

[12] 42 U.S.C. § 254b(k)(3)(H)(i).

Further, the Secretary should include among the certification criteria for qualified health plans standards to ensure adequate primary care capacity to provide primary care to enrollees near where they live and work, at a wide range of hours, in a linguistically and culturally appropriate manner.

Ensure Adequate Plan Competition and Safety Net Plan Participation in Exchanges

In drafting certification criteria, the Secretary should consider how best to foster competition among plans on the exchanges. We also respectfully request that the Secretary include sufficiently flexible certification criteria so that safety net plans may participate in the exchanges, thereby increasing competition among plans offered on the exchanges. Through years of working together to provide coverage and care for low-income individuals, public health plans and community health centers have developed a mutual understanding of the needs of each other and the patients they serve. Both public health plans and community health centers have developed expertise in providing continuity of care for patients whose eligibility for public assistance changes as their incomes fluctuate. With more options for coverage available to low-income individuals with the advent of subsidized exchange plans, the expertise to provide continuity of care despite changes in coverage will prove invaluable to ensuring that the newly insured receive high-quality care, regardless of insurer.

Conclusion

CHCANYS appreciates the opportunity to provide input into HHS's planning efforts for implementation of the exchange and looks forward to working with New York State and federal officials to realize the full potential benefits of health reform in New York.

Sincerely,

Elizabeth Swain
Chief Executive Officer