Comments to the Department of Health and Human Services
Centers for Medicare & Medicaid Services

RE: Draft 2016 Letter to Issuers in the Federally-Facilitated Marketplaces
by Community Catalyst
January 12, 2015

Community Catalyst respectfully submits the following comments to the Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) in response to the Draft 2016 Letter to Issuers in the Federally-Facilitated Marketplace (FFM), released on December 19, 2014.

Community Catalyst is a national non-profit advocacy organization dedicated to securing access to quality, affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state, and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone – especially vulnerable members of society.

We greatly appreciate the opportunity to provide comments on the draft letter to issuers that gives insurers, states and consumers helpful guidance about how Marketplaces will serve consumers in 2016.

Overall, we are very pleased that the policies in the letter move toward greater oversight and transparency over health plans offered by insurers through the federally-facilitated Marketplace. We will focus our comments on areas where the letter may be further improved in the interest of the health and wellbeing of consumers.

Chapter 2, Section 3. Network Adequacy

i. Network Adequacy Standards

We applaud CMS for including a more intensive review to assess the network adequacy of Qualified Health Plans (QHPs). We view this as a positive step toward a more data driven, robust standard for insurers' networks. In particular, we are pleased that provider level data will be analyzed as a part of the certification process. It is critical that network design does not become a way for issuers to discourage people with special health care needs from enrolling with certain carriers.

In addition, it is vital that consumers with chronic health conditions and pediatric populations have access to needed providers. **Specifically, we recommend that CMS add pediatric services and substance use disorder services to the areas of network adequacy concern.** Historically, there have been serious network adequacy concerns and long waiting lists for consumers seeking SUD services; children with special health care needs also face challenges in accessing needed pediatric specialists and sub-specialists.

Further, we support CMS' plan to use data collected to further develop time and distance standards for networks. In addition, we encourage collection of patient data, including use of out-of network providers, to assess the adequacy of plan networks. **We urge HHS to draft regulations in a timely manner on Section 2715A of the ACA to determine a process for collecting this information, and making it available to the public.** This process will be critical in the future to assess, on an ongoing basis, whether networks are too narrow.

We recommend CMS also consider implementing the following standards in future guidance:

- provider-to-patient ratios for specific categories of providers including primary care providers, mental health providers, substance use disorders providers, and other specialists;
- appointment wait-time standards;
- standards for meeting linguistic and cultural competency needs of the service area;
- standards to ensure providers are physically accessible for individuals with disabilities;
- ensure providers are close to public transportation; and
- quality standards that ensure providers included in QHPs' network deliver cost effective and high quality care.

We support CMS in requiring issuers to submit provider lists directly to CMS for evaluation to determine whether the provider networks meet a "reasonable access" standard. In the case where an issuer's network is inadequate, we are pleased that CMS will instruct the issuer to offer contracts to additional providers or provide a justification. However, in their justification, insurers must clearly acknowledge that consumers would receive the same benefit level and at the cost-sharing rate as it would be with in-network providers; and that the process to get approval should be easy and timely. **We recommend that CMS also instruct issuers to include providers located outside of the QHP's service areas that consumers commonly access, to ensure that all enrollees have access to needed care and services.** This could be particularly important for people living near the border of service area, where a provider just over the service area line is easier to access than one on the other side of the service area.

It is very important that CMS hold issuers accountable throughout the year for meeting network adequacy standards – not just at the time of certification. Monitoring will be very important; in 2014, consumers faced barriers to accessing providers due to a reduced provider networks post-certification. Issuers dropped providers from their plans without replacing them in a timely manner and provider directories were inaccurate.

ii. Provider Directory Links

We applaud CMS for strengthening the provider directory requirement. We support a requirement that issuers publish a current, accurate and complete provider directory, updated at least monthly and easily accessible by consumers. This includes being able to view all current providers for a plan on a plan's public website without having to create an account or enter a policy number. This will enhance the transparency of QHP provider directories and help consumers make more informed decisions. Keeping provider directories current is important but still leaves consumers vulnerable. **CMS should consider additional action to protect**

consumers who are locked into a plan choice they made at least in part based on a provider network at the time of enrollment from losing access to needed services.

Chapter 2, Section 4. Essential Community Providers (ECPs)

i. *Evaluation of Network Adequacy with respect to all ECPs*

We are pleased that CMS plans to evaluate QHP applications for sufficient inclusion of ECPs in 2016.

General ECP Standard

A majority of Marketplace enrollees will be low-income, racially diverse, and have chronic health care conditions. It is critical that QHPs are able to meet their needs by maintaining a sufficient number of ECPs with experience providing quality care to consumers from diverse backgrounds and low-income families with the greatest health needs. ECP inclusion is especially crucial in states that will use Medicaid funds as premium assistance to purchase coverage in the Marketplace for individuals with income at 100% of the federal poverty level.

We urge CMS to consider setting the 2016 threshold at 50% of ECPs in a plan's service area. In a geographically large rural county, one health center located in a corner of the county may not be accessible for those who reside on the other side of the county. Minimal standards on ECP inclusion will fail to ensure reasonable and timely access to care for low-income and medically underserved individuals and their families.

With respect to Indian health providers, we are pleased that CMS will require issuers to contract in good faith with all available Indian health providers in the service area.

We appreciate that CMS expanded the list of ECP categories and types via a write in option to include: (1) not-for-profit or State-owned providers that would be entities described in section 340B of the PHS Act but do not receive Federal funding under the relevant section of law; (2) not-for-profit or governmental family planning service sites that do not receive a grant under Title X of the PHS Act; and (3) other providers that provide health care to populations residing in low-income zip codes or Health Professional Shortage Areas. However, **we strongly urge CMS to further expand this list to include: (1) substance use disorders treatment and recovery services providers, and community mental health providers; and (2) pediatric providers, inclusive of pediatric specialists and subspecialists.**

(1) **Substance use disorders treatment and recovery services providers:** The ACA's coverage expansion, Essential Health Benefits requirement and the Mental Health Parity and Addiction Equity Act (MHPAEA) will significantly increase the number of people who can receive and afford substance use disorders treatment. The explicit addition of substance use and community mental health providers as an essential provider category will help to ensure sufficient access to critical services and bolster efforts to integrate and streamline substance use treatment and recovery services with other medical care. Many of these providers are

nonprofit or government-funded agencies that predominantly serve people with low-incomes and those who are medically underserved.

(2) **Essential pediatric community providers for children:** Children are a unique population. To appropriately address the health care needs of all children, regardless of age, networks must include one or more pediatric care setting that is in the geographic area and maintain a full range of primary care and pediatric specialty services. These providers should have the capacity to provide care to all covered benefits at every level of complexity without imposing administrative barriers (i.e. prior authorization processes) and/or high cost sharing. In addition, they can be subject to prior approval for services where there are alternative lower cost options.

ii. Evaluation of Network Adequacy with respect to Dental ECPs

Approximately 83 million people lack access to dental care in this country. Dental access is a longstanding problem for vulnerable populations; specifically, the Medicaid system has largely failed children by not providing them with adequate access to oral health services. The ACA recognizes the importance of dental care through the inclusion of a pediatric dental benefit. However, the network adequacy requirement is vague. Specifically including dental providers and/or requiring inclusion of co-located entities as an ECP category is an important first step in increasing access for consumers.

We are pleased that CMS will review SADPs for the ECP standards. While we understand that dental providers are not available across ECP categories, some FQHCs and/or Community Health Centers (CHC) offer co-located dental services. **We recommend, in this case, that SADPs be required to contract with at least one of these entities.**

Chapter 2, Section 8. Review of Rates

We support CMS' proposal to continue to review all rate increases with consideration of insurers' data and justifications for such increases for all plans seeking to participate in the Marketplace. An assessment of rate increases due to risk assumptions based on new enrollees in Marketplace plans will be of particular importance. We expect that the risk pool will continue to improve in year three of implementation and would expect to either see that reflected in premiums, or if not, see a viable explanation. We also support the proposed continuation of outlier analysis of plan rates to identify more egregious rate increases.

Chapter 2, Section 9. Discriminatory Benefit Design

i. EHB Discriminatory Benefit Design

We are pleased that CMS continues to elevate the important issue of discrimination in Essential Health Benefit (EHB) design. **We encourage CMS to include discriminatory benefit design based on "substance use disorders and mental illness"** in addition to the enumerated list of characteristics that may not be used to discriminate in EHB benefit design as stated in 45 CFR 156.125(a).

While we understand the reasoning for CMS to leave oversight of discrimination in EHB design to states, we are concerned that many states lack the necessary authority or political will to enforce these non-discrimination provisions. **We strongly urge CMS to better define how the state and federal governments will work jointly to monitor and enforce EHB non-discrimination provisions.** As such, we urge CMS to continue to closely monitor state activity and to act as a secondary enforcer to ensure that the EHB provisions are not, for example, excluding care for certain chronic conditions.

One piece of information that is critical to review, but not included in CMS' standards for QHP benefit design standards is an assessment of plan compliance with the Mental Health Parity and Addictions Equity Act (MHPAEA). **We recommend that CMS collect and review the following information as part of the QHP application to assess compliance with non-discrimination standards:**

(1) Documentation of the processes, strategies, evidentiary standards and other factors used to determine medical necessity and to apply other non-quantitative treatment limitations (NQTL) for mental health and substance use disorders and for medical and surgical benefits;

(2) Classifications for mental health and substance use disorders and for medical and surgical benefits.

CMS should use this information to assess whether the application of these standards is comparable to, and applied no more stringently and in the same manner to mental health and substance use disorders than it is for medical and surgical benefits.

ii. QHP Discriminatory Benefit Design

We applaud CMS for considering review and identification of QHPs that are outliers for out-of-pocket costs associated with standard treatment protocols for specific conditions, including several key behavioral health conditions. We support this review as a necessary step in ensuring that QHPs offer consumers accessible treatment that follows the standard of care.

We also appreciate CMS' clarification that age restrictions for clinically appropriate care are discriminatory. We would ask that CMS revise this section to include further clarification for insurers regarding discriminatory plan design and/or the discouragement of enrollment by individuals with chronic mental health or substance use disorders. These restrictions could include limitations on mental health- or substance use disorders-related care, exclusions of certain levels of care (for example, limits on medically necessary long-term residential treatment), or issuer exclusions of drugs that treat certain mental health or substance use disorders or the placement of these drugs exclusively in higher-cost tiers

Chapter 4, Section 3. QHP Issuer Compliance Reviews

We applaud that CMS will allow state flexibility in plan management functions, but will ultimately provide final QHP oversight decisions. While state regulators are most knowledgeable about their own insurance markets, states may lack both capacity and authority to properly enforce QHP compliance.

In addition, **we encourage CMS to use existing groups that work with consumers, including Navigators, Certified Application Counselors (CACs), and consumer advocacy groups, as partners in ongoing evaluation when appropriate.** As people have enrolled in QHPs, those providing assistance on the ground have become well-versed in how well plans meet the needs of consumers. By working with consumer assistance groups and nonprofits that serve vulnerable populations, CMS will gain a more expansive understanding of QHPs' compliance.

Chapter 4, Section 4. FFM Oversight of Agents and Brokers

We applaud CMS' requirements to monitor, license, register and train agents and brokers on FFMs. We urge CMS to retain greater oversight over agents and brokers in 2016. **We recommend that CMS require all agents and brokers to disclose to the FFM and applicants any relationships the agent, broker or sponsoring agency has with QHPs, as well as any other potential conflicts of interest.** We recommend that CMS develops standards for the types of relationships and potential conflicts of interest that must be disclosed, as well as the format for disclosing such relationships or conflicts to applicants (i.e. both verbally and written in plain language). This information is important not only to consumers, but also to CMS in identifying patterns of enrollment that suggest intentional steering to a plan.

We also recommend that the agents and brokers be required to receive training on Medicaid and CHIP, as well as how to provide culturally and linguistically appropriate services, especially to vulnerable low-income families. This training should include how to assist limited-English proficient individuals and immigrant families, especially those with mixed immigration status.

Chapter 6, Section 1. Consumer Case Tracking and Resolution

We applaud CMS for its oversight and evaluation provisions of QHP issuers through tracking complaints. We also suggest that CMS utilize navigator and consumer assistance call centers to track and compile complaints. Finally, we recommend that complaint data be transparent and available, at least in aggregate form, by carrier. This data should be tracked and compiled in a way that distinguishes between behavioral and physical health complaints and allows for a meaningful assessment of parity compliance. This will provide CMS with a more expansive understanding of systemic issues and changes to make in the future.

Chapter 6, Section 3. Meaningful Access

We strongly support CMS' update stipulating that QHPs must provide oral interpretation services in at least 150 languages and by individuals with disabilities. **We urge the additional requirement that QHPs issuers comply with all relevant federal non-discrimination provisions including**:

- Meaningful access requirements at 45 C.F.R. 155.205(c), 155.230(b), and 156.250
- Non-discrimination prohibitions at 45 C.F.R. 156.200(e)
- Non-discrimination provisions of the ACA, Section 1557; Title VI of the Civil Rights Act of 1964; The Rehabilitation Act of 1973, Section 504.

This is an important step to ensure that the needs of people with low literacy, limited English proficiency, and disabilities are met and QHPs are able to fully comply with National Standards on Culturally and Linguistically Appropriate Services (CLAS). In addition to the proposed meaningful access stipulations, we also recommend these provisions to serve limited-English proficient speakers:

- The translation of forms and notices used or produced by QHPs when a language group is five percent of plan enrollees or 500 people. We draw the five percent standard from the Department of Justice (DOJ) and HHS' Limited English Proficiency Guidance, and the 500 person standard from the interim final rule established by the DOJ, HHS and the Department of Treasury governing appeals documents in non-Medicare health plans. All forms and notices should be written in plain language and provided in a manner that ensures meaningful access to limited English proficient individuals.
- Taglines on non-vital notices indicating the availability of translated material or oral interpretation in the top 15 non-English languages in the state. This is the current standard used by Medicare and the Social Security Administration.
- Free access to oral interpreters or bilingual staff on request, regardless of whether thresholds for written translation are met.
- Translation of the content of QHP issuer websites with materials in English into Spanish and include taglines in the top 15 non-English languages in the state, indicating the availability of free language assistance services through an issuer's call center.

<u>Chapter 6, Section 4. Summary of Benefits and Coverage</u>

We strongly support the proposed requirement that issuers make available to individuals eligible for cost-sharing reductions a Summary of Benefits and Coverage (SBC) that accurately represents the plan variation based on this financial assistance. Consumers cannot otherwise understand how the cost-sharing requirements of their plan will differ from the standard silver plan. Such information is critical both for plan selection as well as understanding plan benefits and cost-sharing once enrolled. In the absence of this information, some consumers who would be eligible for cost-sharing reductions may choose bronze level coverage with substantially.

<u>Chapter 6, Section 5. Transparency in Coverage Reporting</u>

We strongly support CMS' requirement that QHPs submit specified information to the Marketplace, Secretary of HHS, the state insurance commissioner, and the public in a timely and accurate manner. Information reported by QHPs should be accessible online and in hard-copy, easy to understand, and accessible to people with low literacy, limited English proficiency and disabilities.

We recommend that data collection and reporting by states to CMS and by federal agencies to the public include detailed information about substance use and mental health coverage. In a recent survey of health advocates nationwide by the Coalition for Whole Health, more than half reported having insufficient information to evaluate the mental health and substance use disorders services covered by their state's health plans. This data should be differentiated according to inpatient, residential and outpatient treatment, integrated substance use and mental health treatment, and any limitations on this treatment or treatment coverage.

We recommend that CMS collect data elements that support the evaluation of network adequacy such as number of claims denied for out-of-network care, enrollees spending on out-of-network care, number of claims denied including type of claim, reason for denial (medical necessity, non-covered benefit, etc.), whether a denial was appealed, and disposition of appeal, for example. This data should be publicly available. Consumer access to this type of data informs their plan choice, holds plans accountable, and is an important barometer of health care access.

Thank you for the opportunity to provide comments on this draft letter, and for continuing to make consumers a priority in your work implementing the Affordable Care Act. If you have any questions regarding our comments, please do not hesitate to contact Ashley Blackburn at ablackburn@communitycatalyst.org.

Respectfully submitted,

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