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Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attn: CMS-9937-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

**Re: Comments on Proposed Rule CMS-9937-P (RIN 0938-AS57); Notice of Benefit and Payment Parameters for 2017**

Dear Acting Administrator Slavitt:

Bi-State Primary Care Association is pleased to submit comments in response to CMS-9937-P, the Notice of Benefit and Payment Parameters for 2017. Established in 1986, Bi-State is a nonpartisan, nonprofit 501(c)(3) charitable organization that promotes access to effective and affordable primary care and preventive services for all, with special emphasis on underserved populations in Vermont and New Hampshire. Bi-State works with federal, state and regional health policy organizations, foundations and payers to develop strategies, policies and programs that provide and support community-based primary health care services in medically-underserved areas. Our members include Community Health Centers, which include Federally Qualified Health Centers (hereafter interchangeably referred to as Health Centers or FQHCs); Rural Health Clinics; private and hospital-supported primary care practices; Community Action Programs; Health Care for the Homeless programs; Area Health Education Centers; Clinics for the Uninsured; and social service agencies.

With over 9,000 sites nationwide, Health Centers provide affordable, comprehensive primary care to over 24 million medically-underserved individuals and serve a critical role in the success of the Marketplaces in every state for two key reasons. First, Health Centers serve as the medical home for millions of Americans who are eligible for reduced-cost coverage through the Marketplace. While over 70% 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. Second, Health Centers are a key source of outreach and enrollment (O&E) assistance nationally. Almost all Health Centers receive grants from the Health Resources and Services Administration (HRSA) to employ Certified Application Counselors (CACs). In 2014 alone, Health Centers employed over 7,000 CACs, and between July 2013 and June 2015, Health Center O&E staff assisted individuals with understanding and enrolling in their health insurance options over 12 million times.

Serving 235,000 patients, the FQHCs in Vermont and New Hampshire work daily on O&E techniques to enroll eligible patients into our State Exchanges. These Marketplace based offerings allow for eligible patients to purchase affordable insurance coverage. A great deal of Health Center patients eligible for the Marketplace are also eligible for APTCs and cost sharing reductions. Last year in New Hampshire, more than 53,000 consumers were enrolled in affordable health insurance through the Marketplace, 70% qualified for an average tax credit of \$244 per month and 43% obtained coverage for \$100 per month or less after applicable tax credits. By midyear last year in Vermont, nearly 32,000 consumers obtained affordable health insurance through Vermont Health Connect, 62% of enrollees qualified for a premium tax credit and nearly 40% of the newly enrolled fell into the key demographic of 18-34 year olds.

Bi-State is focusing its comments primarily on issues that are of particular importance to Health Centers and the patients they serve. Bi-State's comments begin by summarizing our comments and then we provide more detailed comments. In addition to our comments, we fully endorse the National Association of Community Health Center's letter that will be submitted before the deadline. With the National Association of Community Health Center's permission, our letter uses their template and parallels their comments and concerns.

### **SUMMARY OF COMMENTS:**

#### **ENROLLMENT ASSISTANCE:**

Bi-State supports CMS' proposals to expand the role of, and training for, Navigators to include post-enrollment and related services, as this expanded role will more closely mirror the role currently played by Health Centers. Bi-State recommends that:

- Navigators be required to ensure that underserved and/or vulnerable populations within the Exchange service area receive targeted assistance, but not required to provide this targeted assistance directly.
- CMS ensure that consumers fully understand the limitations on Navigators providing tax-related assistance.
- CMS should carefully plan, monitor and update training for Navigators and other O&E providers, particularly around tax issues.
- CMS should clarify what constitutes "inducement(s) for enrollment" and how they differ from "creative outreach and education strategies."
- CMS should coordinate with HRSA on performance, registration and reporting requirements that affect CACs at Health Centers.

#### **GRACE PERIODS:**

Bi-State supports CMS' proposal to provide increased flexibility around grace periods and disenrollment requirements.

#### **OPEN ENROLLMENT PERIODS:**

Bi-State recommends that CMS better align Open Enrollment with tax season by scheduling the annual Open Enrollment Period from November 15 to March 15.

#### **EXEMPTIONS:**

Bi-State strongly supports CMS' proposal to eliminate unnecessary paperwork for individuals seeking an exemption from the shared responsibility requirement due to their state's decision not to expand Medicaid.

#### **STANDARDIZED OPTIONS:**

Bi-State supports CMS' proposals to establish standardized options for Qualified Health Plans (QHPs).

#### **NETWORK ADEQUACY:**

In addition to time and distance, Bi-State strongly encourages CMS to include a second metric in the federal default standard. This metric could be either a provider to population ratio or a measure of wait times to schedule an appointment. In addition, Bi-State recommends that states be required to apply a minimum of two quantifiable metrics; one that is appropriate for rural areas (e.g., time and distance), and one that is appropriate for more populated areas (e.g., provider to patient ratio or wait times, etc.).

#### **ESSENTIAL COMMUNITY PROVIDERS (ECP):**

While we believe that CMS should include an "any willing provider" requirement for all ECPs, Bi-State recommends that, at a minimum, CMS require QHPs to offer any willing FQHC a legally compliant contract. Bi-State supports CMS' proposal to count the total number of FTE practitioners at a single location in both the numerator and denominator when determining if a QHP has met the ECP participation standard. However, we request that CMS state explicitly in the Final Rule that QHPs may not contract directly with individual providers working with an ECP; rather, they must contract with the ECP as an entity.

**THIRD PARTY PAYMENT OF PREMIUMS:**

Bi-State strongly encourages CMS to require QHP issuers to accept third-party payments from not-for-profit, charitable organizations subject to "guardrails" designed to protect the risk pool. Bi-State also strongly recommends that CMS permit FQHCs to pay for individuals' QHP premiums using "non-program income."

**SPECIFIC COMMENTS:**

**ENROLLMENT ASSISTANCE: §§ 155.205, 155.210 and 155.215**

While Health Centers' O&E workers are generally CACs, we have a strong interest in the Navigator and non-Navigator assistance personnel programs. This is because all three types of assisters have a shared mission of providing outreach, education and enrollment assistance to those in need. In addition, some Health Centers and state Primary Care Associations (including Bi-State) also serve as Navigators or non-Navigator assistance personnel. Therefore, our comments on this section reflect both our shared mission and our experience assisting consumers with O&E activities.

Bi-State is generally supportive of CMS' proposals, as we think most of them will help to strengthen the Navigator and non-Navigator programs. However, we want to ensure that these requirements do not become overly burdensome for the individuals providing the assistance. In addition, we are cautiously supportive of the provisions surrounding providing tax assistance, as Navigators are not allowed to provide tax assistance. As discussed below, we seek clear and precise definitions and trainings on what will be expected of Navigators in this area. We also request that the Exchanges commit to offering thorough trainings on these new requirements.

Specifically:

- **§155.210(e)(8): Bi-State recommends that Navigators be required to ensure that underserved and/or vulnerable populations within the Exchange service area receive targeted assistance but not required to provide this targeted assistance directly.** Bi-State appreciates CMS' focus on the needs of underserved and/or vulnerable populations, as demonstrated by the proposal to require Navigators in all Exchanges to provide targeted assistance to these populations within the Exchange service area. However, we are concerned that *requiring* Navigators to provide this assistance *directly* could be often redundant and inefficient.

Under the terms of their O&E grants from HRSA, Health Centers are required to offer O&E services to their patients and the surrounding community. By law, Health Centers target medically underserved areas and populations; therefore, they have been providing a full range of O&E services to the underserved and/or vulnerable populations in their service areas generally since 2013. Requiring Navigators to target populations already served by Health Centers is redundant and will result in resources being diverted from areas where they could be used more effectively. For these reasons, Bi-State recommends that Navigators be required to coordinate with other official O&E providers (e.g., Navigators, non-Navigator assistance personnel and CACs, including those in Health Centers) in each service area to ensure that all underserved and/or vulnerable populations are receiving targeted assistance. However, if another official O&E provider has already provided targeted services to an underserved and/or vulnerable population, the Navigator should not be required to provide this assistance directly.

In addition, we support the proposal to permit Federally Facilitated Exchange Navigator grant applicants an opportunity to reach out to vulnerable and/or underserved communities beyond those identified by in the Funding Opportunity Announcement, and we recommend that this proposal be expanded to State-Based and State-Partnership Exchanges.

- **155.210(e)(9): Bi-State supports expanding the role of, and training for, Navigators to include post-enrollment and related services, as this expanded role will more closely mirror the role currently played by Health Centers.** Bi-State supports the proposal to expand the types of assistance which Navigators will provide to include post-enrollment services (e.g., filing eligibility appeals, understanding how to use coverage effectively and applying for exemptions). Health Centers have provided these services to clients since the first Open Enrollment Period and have found that they are very beneficial to patients.
- **§155.210(e)(9): Bi-State recommends that CMS ensure that consumers fully understand the limitations on Navigators providing tax-related assistance.** As mentioned above, Bi-State is cautiously supportive of the proposals to require Navigators to provide assistance on tax-related issues such as “explaining the general purpose of Internal Revenue Service (IRS) Form 8965 to consumers... and explaining how to access this form and related tax information on irs.gov.” We also agree that Navigators should not provide tax assistance or interpret tax rules. Given these distinctions, Bi-State thinks it is important that consumers be clearly informed about the limitations of the Navigators’ role regarding tax information. We, therefore, support CMS’ proposal that “prior to providing this information and assistance [regarding tax forms], Navigators provide consumers with a disclaimer stating that they are not acting as tax advisers and cannot provide tax advice.” We recommend that this disclaimer be provided both verbally and in writing, and in a linguistically-appropriate manner.
- **§155.210(b)(2)(v) through (viii): CMS should carefully plan, monitor and update training for Navigators and other O&E providers, particularly around tax issues.** Bi-State appreciates CMS’ statement that:

“To ensure that Navigators in all States receive training in every area for which there would be a corresponding Navigator duty, we propose to require all Exchanges, including State Exchanges, to provide training that would prepare Navigators for the additional areas of responsibility proposed in this rulemaking.”

Given Health Centers’ extensive experience in O&E activities, we wish to emphasize the critical importance of this training, particularly around tax issues. We, therefore, recommend that CMS invest significant effort in developing, monitoring and updating training for Navigators and other O&E staff.

- **§§155.210(d)(6) and 155.225(g)(4): CMS should clarify what constitutes “inducement(s) for enrollment” and how they differ from “creative outreach and education strategies.”** Bi-State appreciates the additional information on the use of promotional items and gifts; however, we seek further clarification. Specifically, we request clarification on what constitutes an “inducement to enrollment” and how this differs from “creative outreach strategies.” We also ask CMS to consider how a proposal to ban all gifts of any value could adversely impact or complicate events such as health fairs that consist of multiple organizations or hosts that offer a drawing for an item that exceeds nominal value. We contend that these types of activities are not inducements for enrollment given that the drawings are not limited to those who enroll; however, we request CMS clarification on this point.
- **§155.225(b)(1): CMS should coordinate with HRSA on performance, registration and reporting requirements that affect CACs at Health Centers.** As stated previously, most Health Centers receive grant funding from HRSA to serve as CACs. These grant funds come with numerous conditions around both performance and reporting. In general, we request that CMS work with HRSA when finalizing these rules to ensure that no requirements in this rule contradict or are duplicative of requirements under the HRSA CAC grants. For example, proposed §155.225(b)(1) states that each CAC-designated organization must provide the Exchange with information and data related to the number and performance of its CACs and the assistance they provide. Since Health Centers report this type of data to HRSA, we request that CMS and HRSA work collaboratively to align these requirements; thereby, ensuring that Health Centers are not subject

to duplicative or overly burdensome reporting demands. We also encourage CMS and the Exchanges to coordinate with HRSA when “designating” Health Centers as CAC entities, again with the goal of avoiding duplicative requirements.

**GRACE PERIODS: §155.400(g)**

**Bi-State supports CMS’ proposal to provide increased flexibility around grace periods and disenrollment requirements.** This will avoid enrollees having their coverage terminated when they owe only a de minimis amount of premium. In addition, we support CMS’ proposal that issuers must implement such a policy uniformly and without regard to health status, and that the premium payment threshold adopted is reasonable.

**OPEN ENROLLMENT PERIODS: §155.410(f)(2)(i) through (iii)**

**Bi-State recommends that CMS better align Open Enrollment with tax season by scheduling the annual Open Enrollment Period (OEP) from November 15 to March 15.** Bi-State supports CMS’ proposal to start the Marketplace’s annual OEP in November, as this coincides with the OEPs for many employer sponsored insurance plans. However, given the connections among Marketplace coverage, shared responsibility payments and the tax code, Bi-State also thinks that the annual OEP should be aligned with tax preparation season. Tax time is an excellent time for individuals to enroll, as it is the time when they are most aware of their earnings from the previous year and able to predict future income. It is also when awareness of the shared responsibility payments is at its highest.

For these reasons, Bi-State recommends that CMS establish an annual OEP of November 15 to March 15. The November 15 date will provide some overlap with most end-of-year OEPs for employer sponsored insurance. In addition, while a March 15 end date will not cover the entire tax preparation season, the majority of lower-income taxpayers typically file their taxes early, so this end date will encompass many of them.

**EXEMPTIONS: § 155.605(d)(5)**

**Bi-State strongly supports CMS’ proposal to eliminate unnecessary paperwork for individuals seeking an exemption from the shared responsibility requirement due to their state’s decision not to expand Medicaid.** Specifically, we support CMS’ proposal to remove the requirement that individuals who are ineligible for Medicaid due to their state's not implementing the Affordable Care Act expansion must apply to Medicaid and receive a rejection prior to seeking an exemption.

**STANDARDIZED OPTIONS: § 156.20**

**Bi-State supports CMS’ proposals to establish standardized options for QHPs,** as this will make it easier for clients to compare plans and select the one most appropriate to their situation.

**NETWORK ADEQUACY: §156.230**

Bi-State has concerns about the proposed federal default standard at §156.230(d), which is limited to time and distance measured at the county level. While a time and distance standard may be appropriate in rural areas, it can easily mask inadequate access in more populated areas. For example, in an underserved urban area, a QHP with a low number of providers relative to the size of the patient population would score well on a time and distance standard (because it would not take long for patients to travel to the providers’ offices), but patients could face extremely long waits to get appointments. **In addition to time and distance, Bi-State strongly encourages CMS to include a second metric in the federal default standard. This metric could be either a provider to population ratio or a measure of wait times to schedule an appointment.**

Bi-State supports CMS' general proposal that for states operating under a Federally Facilitated Exchange, either: the state must apply quantifiable metrics to evaluate the network adequacy of QHPs offered in the state; and the metric(s) used must be commonly used in the health insurance industry, be included in a list of metrics provided by CMS; and CMS must review and approve the use of this metric in advance of the start of the QHP certification cycle or else CMS will conduct an independent review of the adequacy of each QHP's network using a federal default standard. However, for the reasons outlined above, **Bi-State recommends that states be required to apply a minimum of two quantifiable metrics; one that is appropriate for rural areas (e.g., time and distance), and one that is appropriate for more populated areas (e.g., provider to patient ratio or wait times).**

Bi-State supports the following proposals offered by CMS:

- §156.230(e)(2): When a provider is terminated without cause, QHPs must allow enrollees in "active treatment" to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates.
- 156.230(f): Under certain circumstances, QHPs must count cost sharing paid by an enrollee for an Essential Health Benefit provided by an out-of-network provider in an in-network setting towards the enrollee's annual limitation on cost sharing.

#### **ESSENTIAL COMMUNITY PROVIDERS (ECP): §156.235(a)(2)(i)**

As we have mentioned in past comments, Bi-State believes that adequate access to primary care services is a critical component of any QHP network, and FQHCs are the largest single source of primary care in medically underserved areas. Improving access to primary care is a leading tenet in the Affordable Care Act and, thus, **while we believe that CMS should include an "any willing provider" requirement for all ECPs, we recommend that, at a minimum, CMS require QHPs to offer any willing FQHC a legally compliant contract.** This approach would have a greater impact on expanding meaningful access to the low-income and medically underserved.

**Bi-State supports CMS' proposal to count the total number of FTE practitioners at a single location in both the numerator and denominator when determining if a QHP has met the ECP participation standard.** This approach will ensure that participation rates reflect the actual number of providers available to see patients, as opposed to the number of sites.

**However, we request that CMS state explicitly in the Final Rule that QHPs may not contract directly with individual providers working with 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.

#### **THIRD PARTY PAYMENT OF PREMIUMS: §156.1250**

**Bi-State strongly encourages CMS to require QHP issuers to accept third-party payments from not-for-profit, charitable organizations subject to "guardrails" designed to protect the risk pool.** Expanding the types of organizations that may assist Marketplace enrollees with their premiums will significantly expand the impact of the Affordable Care Act, as it will make it easier for many individuals to enroll in QHP coverage. It would also increase fairness, as individuals with HIV/AIDS are currently eligible for these payments, while individuals with other illnesses are not despite the fact that not-for-profit, charitable organizations are willing to provide them on their behalf. While Bi-State understands that permitting third-party payments could create concerns about biasing the risk pool, these concerns could be offset by establishing "guardrails" such as: prohibiting the organizations from providing assistance to individuals who are eligible for other Minimum Essential Coverage; requiring that assistance be provided for a minimum length of time; and requiring that

organizations have an explicit set of rules for determining which individuals receive assistance and apply them consistently.

**Bi-State strongly recommends that CMS permit FQHCs to pay for individuals' QHP premiums using "non-program income."** Bi-State recognizes that special concerns would arise if FQHCs were to pay for patients' QHP premiums using "program income" related to their status as a grantee or Look-Alike under Section 330 of the Public Health Center Program.<sup>1</sup> However, FQHCs often have non-program income, meaning income that they receive independent from their status as a Section 330 grantee or Look-Alike. As these funds are unrelated to a Health Center's 330 status or budget, FQHCs should be permitted to use them to support QHP premiums as long as they meet the requirements established for all other not-for-profit, charitable organizations.

\* \* \*

Thank you for the opportunity to comment on this proposed rule. Please do not hesitate to contact me at (603) 228-2830 extension 112 or via e-mail at [tkuenning@bistatepca.org](mailto:tkuenning@bistatepca.org) if you require clarification on the comments presented above.

Sincerely,



Tess Stack Kuenning, CNS, MS, RN  
President and Chief Executive Officer  
Bi-State Primary Care Association

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<sup>1</sup> "Program Income" is defined in HRSA Policy Information 2013-01, available [here](#), as "all anticipated program income sources (e.g., fees, premiums, third party reimbursements, and payments) that are generated from the delivery of services, and from "other revenue sources" such as state, local, or other federal grants or contracts (e.g., Ryan White, HUD, Head Start), private support or income generated from fundraising or contributions" in support of the Health Center's HRSA-approved Section 330 scope of project.