December 21, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services

Kevin Counihan
Administrator
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services

Department of Health and Human Services
200 Independence Avenue S.W., Room 445-G
Washington, DC 20201

RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017 (CMS-9937-P/RIN 0938-AS57)

Dear Administrator Counihan,

The Association of Asian Pacific Community Health Organizations (AAPCHO) appreciates the opportunity to comment on HHS' Notice of Benefit and Payment Parameters for 2017 proposed rule.

AAPCHO is a national not-for-profit association of 35 community-based health care organizations, 29 of which are Federally Qualified Health Centers (FQHCs). AAPCHO members are dedicated to promoting advocacy, collaboration, and leadership to improve the health status and access of medically underserved AA&NHOPIs in the U.S., its territories, and its freely associated states.

AAPCHO members focus on providing services that are uniquely appropriate to their patient populations including: comprehensive primary medical care, culturally and linguistically appropriate health care services, and non-clinical supportive enabling services such as interpretation and case management. On average, AAPCHO's health centers a much higher rate of patients who are Limited English Proficient (LEP) (50% vs. 23%) with some health centers serving as many as 99% LEP individuals.

As an Association of Community Health Centers supporting the needs of Asian American, Native Hawaiian, and Other Pacific Islanders, AAPCHO clinics see first-hand the impact of effective and appropriate in-language care on AAPCHO members' patients. We support the need to provide standards on the provision of in-language care, to ensure that patients are receiving adequate care within their plans. As safety-net clinics with large investments in culturally and linguistically appropriate

A 300 Frank H. Ogawa Plaza, Suite 620, Oakland, CA 94612 | T (510) 272-9536 | F (510) 272-0817

WWW.AAPCHO.ORG

services, our members often encounter those who remain unconnected to their essential right to care because of language and other barriers.

AAPCHO supports the comments submitted by the National Health Law Program, particularly on the comments written on network adequacy, the functions of an exchange, eligibility standards for exemptions, access to provider directory, and provider-covered person ratios/geographic access standards sections, particularly as they relate to language access barriers and proposed solutions.

§ 156.230 – Network Adequacy Standards

Many AAPCHO patients newly enrolled in QHPs found that their trusted provider within the health center was not within their network. AAPCHO clinics, when attempting to negotiate payment with QHPs, found themselves offered rates below Medicaid or below market reimbursement rates. For these reasons and others, network adequacy protections and regulations are critical to achieve adequate and effective care for the patients that have been enrolled. We encourage HHS to develop appropriate measures and parameters of network resiliency that can be incorporated into future regulations. We appreciate the suggestion in the preamble that HHS develop a system for rating network breadth which can be reported on during QHP enrollment to help guide consumers' plan selection.[1] However, we would like to ensure that the languages spoken by providers are also included in the rating system.

In addition, HHS requests comments on transparency of issuers' criteria for selecting and tiering providers and whether issuers should be required to make their selecting and tiering criteria available for review and approval by HHS and the state. It often appears that inclusion of providers is being based largely on price, not on the quality of care provided. Insurers do not use uniform or standardized cost or quality criteria to select or tier providers, and this lack of consistency is confusing both to patients and to providers. We recommend that HHS require insurers to make their criteria for selecting and tiering of providers available both to regulators and to the public.

Strong HHS regulation of QHP networks is essential, as QHPs serve a comparatively vulnerable population. HHS's network adequacy standards apply to individual market QHPs that serve a very high number of low-income individuals and/or limited English proficient individuals. A recent report from California noted that 23 percent of 2015 Exchange enrollees in selected a non-English language as their preferred language.[2] Similarly, a report on 2015 enrollment in New York's Exchange

[1] 80 Fed. Reg. at 75,552.
[2] Covered Cal. & Cal. Dept. Health Care Servs., California Eligibility and Enrollment Report: Insurance Affordability Programs (2015),
[3] NY State of Health, 2015 Open Enrollment Report: Insurance Affordability Programs (2015), http://nystateofhealth.ny.gov/pdf/2015%20NYSOH%20Open%20Enroll

found that 18 percent of enrollees there selected a language other than English as their preferred language.[3]

We commend HHS for proposing additional consumer protections aimed at ensuring that QHP enrollees can actually obtain the essential health benefits covered under their plans. We urge HHS, however, to go further to adopt more specificity in this regulation to ensure that consumers have robust protections to ensure their access to the essential health benefits through adequate provider networks. We describe our additional suggestions in detail below.

a. § 156.230(a) – General Requirements

We are concerned that too often tiered network plans increase consumer cost-sharing. For example, in these plans, the QHP might cover physician services provided by "in-network" or "first tier" providers subject to a $40 co-payment. In many cases, the enrollee's share of the cost of care provided by out-of-network or higher tiered providers is not included in calculation of a plan's actuarial value, and does not count toward the enrollee's deductible or out-of-pocket maximum. Given the enormous cost of accessing out-of-network or higher tier providers in some of these plan models, HHS must ensure that the plan's network or first tier provides enrollees with adequate access to out-of-network providers.

RECOMMENDATION: We suggest amending § 155.230(a) to ensure that all QHPs, regardless of model, provide access to covered services through an adequate provider network:

- Each QHP issuer that has a provider network must ensure that the lowest cost tier of in-network providers meets the following standards:

b. § 156.230(b) – Access to Provider Directory

We appreciate that starting in 2016, HHS will require QHP provider directories to include a range of salient information, including the provider's affiliations, location, capacity for new patients, and specialty type. We urge HHS to require directories to also report on additional information that will help QHP enrollees select their plans and providers appropriately. We recommend that HHS clarify that in reporting on their providers' contact information, QHP issuers should include a phone number and website whenever possible. We also suggest that HHS require issuers to report on their providers' office hours, their anticipated time period for accepting new QHP

[3] NY STATE OF HEALTH, 2015 OPEN ENROLLMENT REPORT 15-16 (2015), http://info.nystateofhealth.ny.gov/sites/default/files/2015%20NYSOH%20Open%20Enrollment%20Report.pdf.

A 300 Frank H. Ogawa Plaza, Suite 620, Oakland, CA 94612 | T (510) 272-9536 | F (510) 272-0817
WWW.AAPCHO.ORG

patients, the physical and programmatic accessibility of the provider's office or facility, whether the provider or facility has pediatric experience, any non-English languages spoken by the provider (for individual providers), and any non-English languages spoken by the provider's or facility's staff.

In requiring QHP issuers to report the languages spoken by network providers and their staff, HHS must ensure that any provider or staff member who identifies as speaking another language be competent to do so. We encourage HHS to require the Exchanges to ensure that QHPs assess the language proficiency of their contracted providers, and the providers' staff, who provide services directly in a non-English language. Otherwise, enrollees, as a result of ineffective communication, may experience adverse medical consequences due to a lack of language proficiency. Medical terminology for someone who is not conversationally bilingual may be difficult to explain. We recommend that HHS work with the Exchanges to implement specific competency standards for all those who seek to provide services directly in a non-English language or serve as interpreters and limit those who may list language skills in a provider directory to providers who have established competency.

RECOMMENDATION: We suggest that HHS amend § 156.230(b)(2) as follows:

> For plan years beginning on or after January 1, 2016, a QHP issuer must publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information *including telephone number and web address*, *office hours,* specialty *including whether the provider has pediatric experience*, medical group, and any institutional affiliations, *languages spoken by the provider or staff, accessibility of the provider's office or facility,* in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS and OPM.

c. § 156.230(d)

HHS must establish a national network adequacy standard for QHP issuers, and the same standard should be applied to issuers in state-based marketplaces just as they are in the FFE, and to multi-state plans regulated by OPM just as single-state plans. While we support HHS's leaving the states and OPM with ample room to hold QHPs to higher standards, reflecting the particular needs of each state, we urge HHS to establish a national floor for network adequacy in these regulations. The ACA requires the Secretary of HHS to establish network adequacy requirements for ***all*** issuers seeking certification of QHPs.[4] The current approach to network adequacy standards has resulted in consumer protections varying widely across state lines. Many state-based Exchanges have also declined to directly regulate network adequacy, and have instead delegated this role to their Insurance Commissioners.

[4] 42 U.S.C. § 18031(c)(1)(B).

A 300 Frank H. Ogawa Plaza, Suite 620, Oakland, CA 94612 | T (510) 272-9536 | F (510) 272-0817
WWW.AAPCHO.ORG

The Office of Personnel Management, which regulates the MSPs, has adopted network adequacy regulations that lack any specific or quantitative definition of adequacy, and its implementing guidance has so far failed to provide consumers with any additional protections to ensure real adequacy of their plans.[5] The result is a confusing patchwork for consumers, that has too often resulted in lack of access. HHS must comply with its mandate under the ACA by adopting a federal minimum standard that will apply to all QHP issuers in all Exchanges.

d. §§ 156.230(d)(1), 156.230(d)(2)

The way the regulation is currently written suggests that HHS will approve state standards that are less stringent than the federal "default" it intends to set forth in the annual letter to issuers. We strongly suggest that HHS set a federal minimum standard, rather than a federal default. A minimum standard will still give states the flexibility to set more detailed or more stringent standards at their option, but will set a floor to ensure that enrollees in all states are enrolled in plans that meet minimum standards. HHS should not allow its federal minimum standard to be diluted by states' adopting standards that are not as stringent.

e. § 156.230(d)(2)

We appreciate that HHS plans to set forth specific provider-covered person ratios and geographic access standards for FFE plans in the forthcoming letter to issuers. We commend HHS for taking this enormous step to establish quantitative standards for network adequacy in the Exchanges. All stakeholders benefit when the standards are clear and easy to measure. We praise HHS for proposing for the first time to use a public quantitative network adequacy standard for QHP issues.

I. Geographic access standards

If a QHP's provider network only includes providers who are hundreds of miles away from its enrollees, it has not provided sufficient access to covered services.[6] As a result, AAPCHO recommends that HHS establish specific criteria to measure the maximum travel time and distance to providers---some AAPCHO member centers see patients from 80 zip codes because AAPCHO community health centers are often the only places where in-language services are provided. We suggest that HHS's criteria should explicitly account for variation in travel patterns, modes of transportation, and geography, including by requiring QHPs that serve communities along political borders to include in their networks providers located in neighboring counties and states, where appropriate considering existing patterns of care.

---

[5] *See* 45 C.F.R. § 800.109; OFFICE OF PERSONNEL MANAGEMENT, MULTI-STATE PLAN PROGRAM CALL LETTER 6 (2014).

[6] *See, e.g.,* Stephen C. Dorner *et al., Adequacy of Outpatient Specialty Care Access in Marketplace Plans Under the Affordable Care Act,* 314 J. AM. MED. ASSN. 1749 (2015), http://jama.jamanetwork.com/article.aspx?articleid=2466113.

A 300 Frank H. Ogawa Plaza, Suite 620, Oakland, CA 94612 | T (510) 272-9536 | F (510) 272-0817
WWW.AAPCHO.ORG

QHPs that are unable to meet geographic access standards should be encouraged to provide regular scheduled or as-needed transportation from areas within a designated area to network primary care providers, hospitals, and clinics, as necessary to ensure that such facilities remain reasonably accessible. Further, Exchanges should urge these QHPs to dispatch mobile health care vans to locations within the designated area at regular scheduled times, at least quarterly, or more frequently if medically necessary.

Because geographic access standards are well-established and tested, we strongly encourage HHS to adopt specific minimum standards into the text of the regulation. The quantitative access standards suggested below, taken as a whole, will strike a balance between reasonable access and issuer flexibility. They are based on the standards that currently apply to all state-licensed plans in California—a large diverse state, with both large urban cities, and many sparsely populated, rural areas. We believe that if the standards that have been tested and work in a large state like California can be applied nationally as a minimum standard that all QHP issuers must meet.

RECOMMENDATION: We suggest that HHS add a new subsection to § 156.230(d)(2)(A) as follows:

(A) Geographic access to care, considering the geography, travel patterns, and the means of transportation ordinarily used by QHP enrollees. Except as provide in subsection (v) below, the QHP issuer shall ensure that:

(i) 90% of enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider.

(ii) 90% enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated hospital, which has a capacity to serve the entire dependent enrollee population based on normal utilization, and, if separate from such hospital, a contracting or plan-operated provider of all emergency health care services. Emergency health care services must have contracts with the primary care providers within the QHP.

(iii) 90% enrollees have a residence or workplace within 60 minutes or 30 miles of a contracting or plan-operated laboratory, pharmacy and similar ancillary facilities that dispense services and goods by order or prescription on the primary care provider.

(iv) The QHP issuer shall account for existing patterns of care in its service area, and shall contract with providers in contingent areas, including out-of-state or out-of-county, as appropriate to meet the needs of enrollees.

(v) If a QHP demonstrates that it cannot meet the criteria described in section (2)(A), the Exchange shall determine alternative standards for the QHP. Alternative standards must be approved by the Secretary of HHS before they may be implemented. Alternative

A 300 Frank H. Ogawa Plaza, Suite 620, Oakland, CA 94612 | T (510) 272-9536 | F (510) 272-0817
WWW.AAPCHO.ORG

standards shall be approved when the QHP demonstrates that it cannot meet the criteria described in section (2)(A) above because additional travel is necessary due to the absence of providers (including providers not part of the network, or providers who do not speak a patient's language) in the area. Prior to approval, the QHP shall submit a detailed access plan that demonstrates that it will provide access to medically necessary services, using methods such as:

(I) Providing regular scheduled or as-needed transportation from areas within a designated area to network primary care providers, hospitals, and clinics, as necessary to ensure that such facilities remain reasonably accessible; or

(II) Dispatching mobile health care vans to locations within the designated area at regular scheduled times, at least quarterly, or more frequently if medically necessary.

II. Timely access to care

We emphasize that a network adequacy standard that only evaluates the numbers, types, and locations of providers may not be enough to ensure that enrollees have access to all of the essential health benefits, since in most states, providers are not obligated to provide all covered services that fall within the scope of practice of their provider license. Enrollees may not be able to access needed care due to providers' protected refusal rights. For example, if a QHP provides geographic access to a primary care provider who provides prenatal care in Mandarin, but it does not contract with any providers who provide case management and prescriptions for family planning services in its service area in Mandarin, enrollees will not have adequate access to those services. Similarly, in narrow networks, contracted providers may limit the number of QHP enrollees they accept in their practice as patients. The fact that a primary care provider is available a few blocks from an enrollee's home is little comfort to that enrollee if the primary care provider is not accepting new patients.

For this reason, measures of timely access to care are an important complement to provider-covered person ratios and geographic access metrics to help HHS determine with QHP networks are providing real access to the essential health benefits. For this reason, we strongly encourage HHS to also adopt specific regulatory minimum standards for timely access to care. Timely access measures focus on the services provided, rather than the type of provider contracted under a plan. Measuring whether QHP enrollees get access to medically necessary essential health benefits in a timely fashion is fundamental to evaluating whether a plans' network contains the right mix of providers. Timeliness standards are crucial to ensuring that enrollees have access to all of the essential health benefits in a reasonable amount of time, by requiring plans to do more than merely show that they contract with a range of providers, but also by showing that those providers can actually provide needed care in a timely manner. These standards should also

A 300 Frank H. Ogawa Plaza, Suite 620, Oakland, CA 94612 | T (510) 272-9536 | F (510) 272-0817
WWW.AAPCHO.ORG

account for provider office hours, to ensure that services are available when enrollees need them.

The minimum standards we propose here are, like the geographic access standards described above, derived from standards that currently apply to all state-licensed plans in California.

RECOMMENDATION: We suggest that HHS add a new subsection to § 156.230(d)(2)(B), directly following the subsection described above, as follows:

(B) Timeliness of access to care and enrollee services. Each QHP issuer must demonstrate that its written standards ensure that its contracted provider network for each QHP has adequate capacity and availability of licensed health care providers to offer enrollees appointments as follows:

(i) Urgent care appointments for medical or dental services shall be available within 48 hours of the request for appointment, except as provided in (vi);

(ii) Non-urgent appointments for primary and specialty care shall be available within 15 business days of the request for appointment, except as provided in (vi) and (vii);

(iii) Non-urgent appointments with a non-physician mental health care provider shall be available within 10 business days of the request for appointment, except as provided in (vi) and (vii);

(iv) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition shall be available within 15 business days of the request for appointment, except as provided in (vi) and (vii);

(v) Non-urgent dental appointments shall be offered within 30 business days of the request for appointment, except as provided in (vi);

(vi) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee;

(vii) The applicable waiting time for a particular appointment must be shortened if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined that it is medically necessary for the enrollee to receive care more quickly;

A 300 Frank H. Ogawa Plaza, Suite 620, Oakland, CA 94612 | T (510) 272-9536 | F (510) 272-0817
WWW.AAPCHO.ORG

(viii) The network providers shall offer hours of operation that are convenient to the population served under the plan and do not discriminate against QHP enrollees; and
(ix) Services included in the contract shall be available 24 hours a day, 7 days a week, when medically necessary.

III. Provider-covered person ratios

The metric for determining appropriate numbers of providers must account for the range of services offered by participating providers, and whether providers are accepting new patients. QHPs enroll high numbers of children, people with disabilities, limited English proficient enrollees, and women of reproductive age. We recommend that HHS annually develop criteria, to be published in a guidance letter, to measure the number of providers that account for variation in specialty type and geography, similar to those used in the Medicare Advantage program. Each year HHS would review and update the criteria based on utilization patterns and clinical needs, and to account for provider capacity.

RECOMMENDATION: We suggest that HHS add a new subsection to § 156.230(d)(2)(C), directly following the subsection described above, as follows:

(C) Numbers and types of providers that meet or exceed the standards established by HHS, and that account for the services offered by networked providers, and the proportion of accepting new patients.

IV. Out-of-network access

We urge HHS to establish specific standards in the regulation under which QHP issuers would be required maintain a process to facilitate an enrollee's obtaining a covered benefit from an out-of-network provider at no additional cost if no network provider is available in a timely manner. Such a standard is vital to ensuring that enrollees have full access to covered health care services. We suggest that HHS establish a standard that would require QHP issuers to maintain a process and criteria for timely evaluation of access to out-of-network providers to obtain covered services without penalty or additional cost to the patient.

V. Language Access

HHS must adopt regulatory standards that account for the capacity of providers to serve limited English proficient (LEP) individuals. Large numbers of LEP individuals are purchasing insurance through the Exchanges and HHS must ensure that those QHPs offer linguistically appropriate supports. While Title VI of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act apply to QHPs, we believe HHS should adopt more explicit standards to ensure effective language services are actually provided. At a minimum, HHS should require all QHP issuers to identify the

A 300 Frank H. Ogawa Plaza, Suite 620, Oakland, CA 94612 | T (510) 272-9536 | F (510) 272-0817
WWW.AAPCHO.ORG

linguistic needs of enrollees and provide free language assistance services at all points of contact. We encourage HHS to adopt additional standards to ensure that LEP enrollees have meaningful access to care, by adopting stronger standards to ensure that enrollees have access to oral interpretation, and by requiring plans to report on bilingual providers and staff (discussed in the section on provider directories, above). When language access services are not available within a service area, QHPs must determine how to define and remedy the gaps in service without creating larger barriers to health access for LEP populations.

Further, HHS should explicitly require plans pay for interpretation services (both foreign language and sign language as needed) for their contracted providers. We ask HHS to require QHP issuers to contract to pay for interpreters directly, including in interactions between provider and patient, to ensure the availability of language services and improve compliance by providers who often do not have the resources to evaluate or pay for competent language services. Before any Exchange certifies a plan for participation, HHS should ensure that the Exchange requires the plan to set forth in detail its process for paying for and guaranteeing timely oral interpretation services, both for its own customer service functions and whenever necessary to facilitate communication between enrollees and providers. These language access policies should be made available to the public on each Exchange's website.

> **RECOMMENDATION:** We suggest that HHS add a new subsection § 156.230(d)(2)(E), directly following the subsection described above, as follows:
>
> > *(E) Timely and adequate access to language-appropriate services at no additional cost to the enrollee. QHP issuers shall assess the linguistic capacity of enrollees and shall provide free language assistance at all points of contact. QHP issuers shall also have a written policy to ensure that enrollees' language access needs are met, which shall provide for the issuers' direct payment of interpreter services; this policy shall be made available to the public on each Exchange's website.*

Thank you for the opportunity to review AAPCHO's comments. If you have any questions or need information clarified, please contact Isha Weerasinghe, AAPCHO's Director of Policy and Advocacy at (202) 331-4600 or isha@aapcho.org

Thank you,

Isha Weerasinghe

Director of Policy and Advocacy

A 300 Frank H. Ogawa Plaza, Suite 620, Oakland, CA 94612 | T (510) 272-9536 | F (510) 272-0817
WWW.AAPCHO.ORG