AAPCHO

ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS

October 6, 2016

Submitted electronically through http://www.regulations.gov

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: ***Proposed HHS Notice of Benefit and Payment Parameters for 2018 (CMS-9934-P)***

AAPCHO respectfully submits the following comments on the Notice of Benefit and Payment Parameters for 2018.

AAPCHO is a national not-for-profit association of 35 community-based health care organizations, including 29 Federally Qualified Health Centers, dedicated to promoting advocacy, collaboration, and leadership that improves the health status and access of medically underserved Asian Americans, Native Hawaiians, and Pacific Islanders (AA&NHPIs) in the U.S., its territories, and its freely associated states. As health care providers, AAPCHO members focus on providing services that are uniquely appropriate to their patient populations, including: culturally and linguistically appropriate health care services, comprehensive primary medical care, and wrap-around enabling services (ES) for the medically underserved throughout the country. For the approximately 500,000 patients our centers serve annually, AAPCHO advocates that the health care system provide access to comprehensive and linguistically and culturally competent care by our member community health center providers and for our patients.

AAPCHO's comments focus on issues of specific relevance to AA&NHPI consumers in the Exchanges. AAPCHO strongly supports the implementation of the Section 1557 final rule and supports CMS' efforts to integrate the strong nondiscrimination provisions into this proposed rule. Wherever possible, CMS should strengthen the provisions of the Exchanges to reflect the 1557 final rule, and build strong and enforceable penalties for non-compliance.

Consumer Assistance Tools and Programs of an Exchange (155.205)

AAPCHO thanks CMS for the continued support for language access provisions, including requiring sample taglines in the top 15 languages spoken by the population in each state. We are deeply concerned, however, by the provisions of this proposed rule that could have the unintended consequence of removing needed taglines in common languages in states and communities across the country.

Current policy says that the top 15 languages spoken by LEP individuals may be determined by aggregating the top 15 languages spoken by all LEP individuals among the total population of **each state**. This provision should be the minimum requirement for providing taglines and information for LEP populations; AAPCHO has previously recommended determining the language taglines at the county level.

This rule proposes clarifications that weaken these standards and allow Exchanges, issuers and web-brokers who operate in multiple States to aggregate the 15 top languages across all the states they serve—rather than on a state-by-state basis. This decision means that some prevalent languages in some states may not be reflected and the aggregated languages would not reflect the unique state-by-state populations.

This aggregation reduces the availability of taglines for groups that have a large presence in certain states but when states are aggregated, their language needs do not rise to the top 15 languages. For example, Kaiser serves California, Colorado, the District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. Even though there are almost 35,000 people with limited English proficiency in California who speak Hmong, that language does not rise to the top 15 languages when California language needs are combined with those of other states that Kaiser serves. California is a very large state and has high numbers of residents with limited English proficiency. When Washington, for example, which houses a few of our member centers, is aggregated with California and other states, residents lose access to several languages including Amharic, German, Cushite, Ukrainian, and Laotian.

This is particularly troubling in the FFEs and SBE-FPs, which operate in the majority of states across the country. All states in the FFE (including FFEs where States perform plan management functions) and the SBE-FPs would be permitted to aggregate languages across all the States in the FFE. Huge regional and state differences exist across the states in the FFE in terms of populations and languages spoken. As an example, in Hawaii, if state

language data were aggregated, residents would not be able to see resources in Ilocano, Laotian, Samoan, Marshallese, Trukese, Hawaiian, Micronesian, Bisayan, and Tongan.

The rule also proposes that a QHP issuer would be permitted to aggregate the LEP population across all states served by the health insurance issuers—both Marketplace and non-Marketplace—to determine the top 15 languages in aggregate. In other words, issuers' tagline requirements for Exchange-based products could be in stark contrast to the populations they actually serve within a state, because the issuer has aggregated languages across all the states they serve. This could create great gaps in service to a significant percentage of populations within a state.

AAPCHO strongly rejects this proposal and urges CMS to maintain the requirement that taglines must be provided in the top 15 languages by state and not by an aggregated measure across states.

With respect to summaries of benefits and coverage (SBC), QHP issuers are still required to provide an addendum with the SBCs with language taglines in the top 15 languages spoken by the LEP populations of the relevant States (or states). The addendum is a separate document and does not count towards the page limit for the SBC; and the taglines in the addendum are not required to also be included in the SBC document. AAPCHO supports including an addendum with tag lines in all of the languages in a county where 10% or more of the population is literate only in a non-English language. In fact, this requirement should be extended to all critical documents.

For website content, Exchanges, issuers or web-brokers are permitted to post a prominent link on their home page to direct individuals to the full text of the taglines indicating how individuals may obtain language assistance services. In HHS's view, providing a prominent link to taglines on the home page gives sufficient notice to consumers that language services are available. AAPCHO raises concerns that this is insufficient and inadequate for LEP consumers. We call on CMS to ensure that this notice is prominent, in large font, and "above the fold" so that LEP consumers can easily and quickly understand their right to access information in other languages and where that information can be found. In reality, including a notice in English for LEP individuals to click on to access the taglines is not a viable option for LEP consumers.

Network Adequacy Standards (156.230)

AAPCHO strongly believes in CMS's work to support to determine the breadth and depth of networks. We appreciate the agency's efforts to give consumers transparent information about the breadth of network. LEP populations in particular need to understand where they can receive culturally and linguistically appropriate care. We again call on CMS to include information about language and cultural competency as part of network adequacy standards.

AAPCHO, is also concerned along with NACHC that CMS did not propose to strengthen network adequacy standards for Marketplace plans in the proposed rule. The lack of stricter requirements, prevent QHPs from offering truly accessible plans, undermining the intent of the Marketplace, which is to ensure access to affordable health care. Given this concern, AAPCHO strongly encourages CMS to strengthen the minimum Federal standards applied to FFE plans, either through regulation or the annual Letter to Issuers. AAPCHO supports NACHC's suggestion that CMS include the following measures and indicators and in future standards to ensure appropriate access:

- a minimum ratio of providers-to-covered-persons for primary care providers and for a range of specialists by specialty (including subspecialists);
- maximum wait times to get a primary care appointment, for first-time and returning patients;
- a maximum time and distance standard to access hospital, emergency care, diagnostic, pharmacy, and ancillary services;
- a minimum number of providers to meet the needs of individuals with limited English proficiency (LEP); and
- a minimum number of providers to meet the needs of consumers with disabilities.

The specific standards should be set according to an evidence-based review of the actual patterns of care, defined by the populations that an entity serves.

Essential Community Providers (156.235)

AAPCHO's members are Federally Qualified Health Centers and are ECPs. We appreciate CMS continued support of ECPs but call for further action to strengthen the issuers investment in having ECPs in network, and to require ECPs to be paid no less than PPS.

CMS proposes to continue the 2017 requirements that a QHP must demonstrate that its network contains the minimum percentage of Essential Community Providers (ECPs) in each plan's services area, with multiple providers at a single location counting as a single ECP for the purposes of satisfying the ECP participation standard.

AAPCHO commends CMS for the language that QHPs demonstrate in its QHP application the number of providers located in a HPSA or five-digit zip code in which 30% or more of the population falls below 200% FPL. AAPCHO also supports NACHC's request for CMS to enforce the statutory provision of the "any willing provider" requirement, for QHPs to contract with ECPs. Section 1311 of the ACA states that QHPs "shall... include... those essential community providers, where available, that serve predominately low-income, medically-underserved individuals." AAPCHO agrees with NACHC's strong request that CMS enforce an "any willing provider" requirement for QHP contracting with ECPs, in all types of Marketplaces, as is stated in the ACA.

CMS states that it is developing a methodology to credit issuers for having multiple providers at a single location for the purposes of meeting the ECP requirement. AAPCHO supports NACHC's comments for CMS to develop such a methodology. In addition, we strongly encourage CMS to state explicitly in the Final Rules for 2018 and future years that QHPs may not contract directly with individual providers working within 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. This approach has enabled QHPs to undermine the intent behind the ECP contracting provisions, while also creating unnecessary confusion and burden for both providers and patients.

At a minimum, CMS should require QHPs to offer legally-compliant, good-faith contracts to all FQHCs in their service areas. FQHCs are the largest single source of primary care in medically underserved areas and for medically underserved populations. Thus, to ensure meaningful primary care access for low-income and medically underserved QHP enrollees, CMS should at a minimum require QHPs to offer good-faith contracts to all FQHCs in their service areas.

Finally, we support the *I Am Essential* coalition's comments, inclusive of strengthening regulations to include more language in ACA's patient protections. As AAPCHO has advocated for before, health plans should not be permitted to place a medication required to treat a condition or ailment on the highest formulary tier when a generic is not available.

As an example, not all dosage forms of entecavir, used to treat chronic hepatitis B infection in adults and children, are available in generic form. Entecavir is the only antiviral medication available for children above the age of 12 that has a high barrier to resistance. However, it is not available as solution in generic form, and some children have difficulty swallowing pills. Formulary tiers need to reflect the diverse needs of patients. If health plans do not abide by these guidelines, they should be subject to Section 1557's enforcement provisions. QHP beneficiaries continue to experience adverse tiering and other barriers, including the lack of prescription coverage within a formulary, high cost-sharing, midyear formulary changes, and as mentioned before, narrow provider networks.

Thank you for the opportunity to submit 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. We're happy to provide you with information from our member centers as well.

Thank you,

Isha Weerasinghe
Director of Policy and Advocacy
Association of Asian Pacific Community Health Organizations