November 27, 2017

Seema Verma, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-9930-P, NPRM Notice of Benefit and Payment Parameters for 2019

Dear Administrator Verma:

Thank you for the opportunity to comment on the HHS Notice of Benefit and Payment Parameters for 2019. As an organization with direct experience in enrolling consumers in health insurance, we have a strong understanding of the work that Navigators undertake and the types of work at which they excel. Navigators have served the critical role of providing consumers with in-person assistance with the Affordable Care Act (ACA) marketplace application, enrollment process, maintenance of coverage, and accessing care once coverage has been achieved.

The Association of Asian Pacific Community Health Organizations (AAPCHO) is a national not-for-profit association of 32 community-based health care organizations, 27 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&NHPIs in the U.S., its territories, and its freely associated states.

Since 2012, AAPCHO and partners have worked to outreach to, educate and enroll nearly 1 million consumers through Action for Health Justice (AHJ), a national collaborative of more than 70 AA and NHPI national and local community-based organizations and health centers.[1] We have seen how the ACA has had an important impact on reducing AA and NHPI health disparities. Since the law's passage, the percent of uninsured AAs has dropped from 15.1 percent in 2010 to 6.5 percent in 2016. For NHPIs, that drop was from 14.5 percent in 2010 to 7.7 percent in 2016.[2]

Considering our expertise, and the experience and feedback on many of these proposals from our partners, we are deeply concerned many aspects of the proposed rule would create unnecessary barriers to coverage and ultimately care for AA and NHPI populations. Below, we address each aspect of the rule. We stress that the rule overall burdens consumers who are limited English proficient (LEP), immigrant or with low levels of health literacy. For these populations, applying for and effectively utilizing health coverage and care is already difficult. We urge CMS to consider how its proposed changes, particularly those that make enrollment and enrollment assistance more difficult, will impact vulnerable populations.

§ 155.20 – Standardized Options

[1] For more about Action for Health Justice, please see: *Improving the Road to ACA Coverage. Lessons Learned on Outreach, Education, and Enrollment for Asian American, Native Hawaiian, and Pacific Islander Communities*. Asian & Pacific Islander American Health Forum, Association of Asian Pacific Community Health Organizations, Asian Americans Advancing Justice | AAJC, and Asian Americans Advancing Justice | Los Angeles, 2014. Available at: http://www.apiahf.org/resources/resources-database/improving-road-aca-coverage-lessons-learned-outreach-education-and-enro

[2] APIAHF analysis of 2010 and 2016 American Community Survey 1-year estimates.

We are in line with the Asian Pacific Islander American Health Forum's (APIAHF) comments to oppose the CMS proposal to eliminate Simple Choice standardized options in 2019. CMS created the standardized option to help consumers make educated choices among potentially confusing plan options. Many consumers have low health literacy and find it difficult to understand the difference between cost sharing structures, particularly those purchasing insurance for the first time. For example, a Kaiser Family Foundation survey found that overall, about one in four consumers were not able to identify key health insurance terms, but far more younger people (43%), uninsured people (47%) and those with a high school education or less (45) scored low.[3] These are the populations who would be most affected by elimination of the Simple Choice plans, as they benefit from the clear demarcation and consistent explanation that allows them to compare plans. Instead, CMS should continue to promote ways that allow consumers to easily compare plans by benefits, costs and other factors.

§ 155.106 and § 155.200 – Flexibility for State-Based Exchanges and State-Based Exchanges on the Federal Platform

We echo the comments of the National Health Law Program that CMS should first prioritize needed technical infrastructure and enrollment process improvements to healthcare.gov given limited resources rather than issues that are state or exchange specific.

§156.100 – §156. 115 - Essential Health Benefits Package

We are deeply concerned about many of the aspects of the proposal to allow states to adopt alternate methods of determining their benchmark plan for QHP selection of Essential Health Benefits (EHB). In particular, we urge CMS not to adopt the proposal to §156.111 to allow states to create a custom set of benefits for the state's EHB benchmark plan. We believe this option would have a detrimental effect on consumer's access to care, particularly consumers who require specific medications or treatments which may be dropped as a result of this proposal.

If finalized, the proposal to allow states to adopt potentially minimal EHB will result in consumers having both less access to care and greater out-of-pocket costs. We believe that CMS should develop policies in a direction where health insurances covers more of a patient's needs, not less. Before the passage of the ACA, too many consumers discovered too late that their insurance did not cover key benefits. For example, the family of Anton Saleh had to sell his family home because his cancer drugs were not approved by his insurer.[4] EHB helped level the playing field to create standardization across states, which had wide variations in which benefits were required prior to the ACA.[5]

Sec 1302(b)(2) of the ACA requires that EHBs be set against a benchmark compared to a "typical" employer plan. In the draft notice, CMS proposes changing the definition of a typical employer plan to a small-group, large-group or self-insured group plan with at least 5,000 enrollees. CMS does not justify this number or explain why it believes such a plan would meet the definition of "typical"

---

[3] Norton et al, *Assessing Americans' Familiarity With Health Insurance Terms and Concepts*, Kaiser Family Foundation, Nov 11, 2014. Available at: https://www.kff.org/health-reform/poll-finding/assessing-americans-familiarity-with-health-insurance-terms-and-concepts/

[4] *Health Care for Me – Anton Saleh*, Asian & Pacific Islander American Health Forum. Available at: http://www.apiahf.org/healthcare4me/anton-saleh

[5] *Health Insurance & Managed Care Indicators - Pre-ACA State Mandated Health Insurance Benefits,* Kaiser Family Foundation. Available at: Https://www.kff.org/state-category/health-insurance-managed-care/pre-aca-state-mandated-health-insurance-benefits/

required by statute. We believe that states may find such a plan that meets this proposed definition but, compared to other plans in the state, would not be typical in benefits or the limits it may place on their use. Such a broad definition of a typical employer sponsored plan may lead to an EHB benchmark plan that makes it difficult for certain populations to get the care they need, such as the 14% of Indian Americans that have diabetes, a rate higher than that of nearly all other racial groups.[6]

Consumers would continue to require services not covered by their state's EHB benchmark, but those services will not be subject to the ACA's important out-of-pocket annual and lifetime maximums. These important caps, which have helped to reduce bankruptcies nationwide by 50%, are a key piece of the ACA that helped not just consumers on the private market, but those with employer sponsored insurance as well.[7] It is concerning than that the proposed rule could theoretically allow a state to choose a benchmark plan that only covers preventive services, only adding in the additional required benefits with no point of comparison.[8]

Moreover, this new complex framework would create a difficult environment for determining whether plan designs are discriminatory, as prohibited by the ACA. Unlike the current system, where states may choose from among 10 plan options with transparency, states may choose from plans that do not cover all 10 EHB or that do not cover them in a balanced way, as required by statute. In this situation, states will need to supplement the benchmark, but there will be no plan to compare this supplement to. In addition, CMS proposes to allow plans to substitute benefits across categories, further blurring the lines and creating greater opportunity for issuers to game the system, such as swapping out benefits relied on by people with chronic conditions. In these scenarios, already taxed state and federal regulators will likely find it difficult to determine which plan designs are discriminatory.

As such, we urge CMS to require states to provide substantial notice and public comment when adopting their EHB benchmark plans, post it on their web site and additionally demonstrate that they have conducted outreach to and considered the feedback from populations, including racially, ethnically and linguistically diverse groups, that may be impacted by changes in their benchmark plan.

In addition, we are concerned that CMS may consider establishing a Federal default definition of EHB, particularly due to the stated reasons for doing so in the proposed rule, to "better align medical risk in insurance products by balancing costs to the scope of benefits." While there is merit in the idea of a federal default for the EHB benchmark, we are concerned that with the explicit goal of balancing costs, CMS will adopt a federal benchmark that will ultimately allow states to adopt a skimpy EHB. Any federal benchmark considered by CMS must follow the statutory requirements for EHB and must provide consumers with robust coverage of the services they need.

§ 156.150 – Application to Stand-Alone Dental Plans Inside the Exchange

---

[6] Spanakis, Elias and Sherita Hill Golden, Race/Ethnic Difference in Diabetes and Diabetic Complications, Curr Diab Rep. 2013 Dec; 13(6). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3830901/

[7] St. John, Allen, How Obamacare Helped Slash Personal Bankruptcy by 50%, Time Magazine, May 4, 2017. Available at: time.com/money/4765443/obamacare-bankruptcy-decline/

[8] Lueck, Sarah, *Administration's Proposed Changes to Essential Health Benefits Seriously Threaten Comprehensive Coverage*, Center on Budget and Policy Priorities, November 7, 2017. Available at: https://www.cbpp.org/research/health/administrations-proposed-changes-to-essential-health-benefits-seriously-threaten.

Like APIAHF, we oppose the proposal to remove actuarial value (AV) requirements in stand-alone dental plans. AV standards allow consumers to make more informed choices when shopping. Allowing an array of plans with different AVs may make choosing a plan harder and could cause consumers to simply forgo the choice of a dental plan in the first place. AA & NHPI populations face disparities in oral health, and therefore it is important that the process for enrolling in a dental plan be as simple as possible.[9]

§ 155.210 and §155.215 – Navigator Program Standards

We express deep concern about the proposed changes to the Navigator program and ask that CMS maintain requirements for Exchanges to 1) have at least two Navigator entities; 2) have at least one community-based and consumer-focused nonprofit Navigator entity; and 3) require that Navigators maintain a physical presence in the Exchange service area. These regulations were put in place to ensure that consumers get the best assistance available and we believe that all three play central roles in helping the most vulnerable populations get enrolled.

AA and NHPI populations face barriers to enrollment, particularly due to issues of language access and cultural supports.[10] For many, only in-person assistance provides the tools needed to enroll in health care. Nearly one in three AAs and one in ten NHPIs speak English less than "very-well," meaning they are limited-English proficient (LEP).[11] While telephone interpretation is an option, we and our partners have found that having in-person assistance in their preferred language facilitates a much more accurate and efficient enrollment process. We also wish to note the important role that in-person assistance plays not just in helping consumers enroll, but also in providing follow-up support to resolve inconsistencies or navigating use of their insurance.

As such, we strongly oppose CMS's proposal to remove the requirements to have at least two Navigator programs per state. One navigator per state is simply not enough, even if the grantee brings on sub-grantees. Fewer navigators would likely mean fewer resources going to each state for in-person assistance, hurting the populations that rely on help for enrollment and follow-up. It is well documented that in-person assistance improves the quality and quantity of enrollment.[12] In addition, having only one grantee per state would greatly reduce the likelihood that entities with relationships with specific populations in a state will receive navigator funding. In reviewing 2017 and previous years of federal Navigator grantees, it is apparent that there is a pattern where many states have such a grantee that meets specific population needs, such as Boat People SOS in Georgia, Fishing Partnership Health Plan in Maine and Great Plains Tribal Chairmen's Health Board in North Dakota. In other states, grantees tend to each target different populations that are hard to reach or require specialized enrollment assistance. Permitting just one grantee per state would greatly

---

[9] Le, Huong et al, *Oral Health Disparities and Inequities in Asian Americans and Pacific Islanders,* American Journal of Public Health, 107(Suppl 1), June 2017. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5497891/

[10] *Improving the Road to ACA Coverage. Lessons Learned on Outreach, Education, and Enrollment for Asian American, Native Hawaiian, and Pacific Islander Communities*. Asian & Pacific Islander American Health Forum, Association of Asian Pacific Community Health Organizations, Asian Americans Advancing Justice | AAJC, and Asian Americans Advancing Justice | Los Angeles, 2014. Available at: http://www.apiahf.org/resources/resources-database/improving-road-aca-coverage-lessons-learned-outreach-education-and-enro

[11] APIAHF analysis of 2016 American Community Survey 1 year estimates.

[12] In-Person Assistance Maximizes Enrollment Success, Enroll America, 2014. Available at: familiesusa.org/sites/default/files/documents/enroll-america/2014%20-%20In-Person%20Assistance%20Maximizes%20Enrollment%20Success.pdf

increase the likelihood that many populations would not be served by an enrollment organization with competency and relationships with their community.

Further, we oppose CMS's proposal to eliminate the requirement that at least one navigator per state must be a to be a community-based and consumer-focused non-profit. Navigators that come from the community are uniquely qualified to understand the needs of its population. Nonprofit navigator groups typically have expertise in one or more communities, like veterans or LEP populations, as well as a trusted name with many community members. These are competencies that non-community groups lack. We have heard from our partners that, as navigator grantees or sub-grantees, t are often the only groups doing enrollment work in their state or area with relationships with AAs or NHPIs and the only groups with interpretation competencies for AA and NHPI languages. We have also heard that there is a trusted relationship between community groups and community members that cannot be replicated by other enterprises, particularly due to the sensitive nature surrounding health and health insurance. We have also anecdotally heard that community groups have greater retention of navigator staff than other organization for similar reasons. From this feedback, it is clear that removing these requirements would limit the ability for consumers to get unbiased, high-quality assistance.

We agree with CMS that entities with physical presence "tend to deliver the most effective outreach and enrollment results" and ask that the existing rules requiring physical presence remain in place. The ACA requires consumers to be able to enroll in coverage through the phone, online, paper, and in person, and the latter option may very well be eliminated if navigators are not required to maintain a presence in the state. Taking away the requirement for an entity to have a physical presence in the area will open the door for entities that are unfamiliar with the community and consumers' needs to take over existing work. It would also likely create insurmountable barriers for enrollment of consumers who lack a phone or access to internet, as well as those who require extensive follow-up assistance. Many of our partners who conduct outreach and enrollment tell us that often their first step when assisting a consumer is to create an email address required for a healthcare.gov account. Consumers with low-levels of technology utilization depend upon in-person assistance for quality enrollment. Similarly, we hear from partners that while the call center has improved its quality, including the quality of interpretation, consumers prefer the one-on-one attention that only an in-person assister can provide. We strongly urge CMS to not make changes that would enable entities to provide *only* remote assistance, rather than in-person assistance, as required by the ACA.

In addition, we urge CMS to provide clarity about what metrics are being used to measure Navigator performance. CMS should include all aspects of statutorily required activities in any measurements used to assess Navigators' work moving forward. The ACA statute requires that Navigators perform tasks far and above merely providing enrollment assistance.[13] However, the metrics used by CMS for determining funding allocations for federally-facilitated marketplace (FFM) Navigators in 2018 were arbitrary and did not include all aspects of Navigator work.[14] The preamble to this proposed rule mentions providing grants to "high performing" entities as well as the "highest scoring" entities, but it is unclear how CMS defines these terms.

---

[13] Sec 1311 (i)(3) of the Affordable Care Act require navigators to conduct public education activities, distribute impartial information, facilitate enrollment, assist with the grievance process and provide information in a culturally and linguistically manner.

[14] Kaiser Family Foundation, *Data Note: Changes in 2017 Federal Navigator Funding* (Washington DC: October 11, 2017), available online at: https://www.kff.org/health-reform/issue-brief/data-note-changes-in-2017-federal-navigator-funding/.

Lastly, we emphasize the importance of the responsibilities that navigators engage in beyond enrollment in marketplace coverage. Their responsibilities do not start and end with open-enrollment, and for example, navigators play important roles in helping consumers apply to CHIP, Medicaid and special enrollment periods. Groups working with AA and NHPI populations see many consumers who consistency return to their enrollment assister to translate notices from the marketplace, resolve inconsistencies, and understand how to use their insurance. Fewer resources directed to community groups will directly lead to reduced enrollment in these communities and higher rates of terminations due to inconsistencies and other resolvable issues. It will also increase burdens for consumers who seek consumer assistance and may have to travel further to do so.

§ 156.1120 - Quality Rating System

The proposed rule asks for comment about whether and how CMS should take into account social risk factors (SRF) in the Quality Rating System (QRS). In general, we recognize the importance of adjusting for social risk factors in payment programs and share concern about both the burden on clinicians who disproportionately serve those with more social risk factors, while at the same time not creating lower standards for improving health outcomes in disadvantaged populations. We strongly believe that it is critical that plans that serve both those impacted by Socioeconomic Status (SES) factors and those with lower numbers of SES factors be held to the same measures in the QRS, but there needs to be a better understanding of the impact of SES on plans using the rating system and data available to determine this impact before determining what methodology can be employed that will not have unintended consequences.

For example, data plays a foundational role in identifying factors and determining what impact, if any, SES is having on plan rating. As such, we strongly recommend that CMS include an explicit reference to public data stratification and reporting in ongoing development of the QRS. CMS should require that in reporting, plans should stratify measures by disparity variables, including race, ethnicity, preferred language, disability status, sexual orientation, and gender identity, psychological and behavioral status, to the extent practicable. Stratified data can help plans identify and distinguish efforts to improve quality from efforts to reduce disparities, which may not correlate without dedicated work. The pubic reporting of stratified data can assist consumers in more effectively using the QRS to determine which plans are best able to meet their needs (such as those providing language access services, for example).

§155.221 – Standards for Third-party Entities to Perform Audits of Agents, Brokers, and Issuers Participating in Direct Enrollment

We are concerned that CMS plans to continue to loosen oversight over direct enrollment in health insurance through websites that are not healthcare.gov and urge it not adopt the proposed changes regarding these entities. While agents and brokers have valuable roles to serve, AA and NHPI communities, particularly among those that are immigrants or LEP, are vulnerable to scams and other misleading schemes. Many consumers are not able to tell the difference between legitimate sites and those that seek to prey on them. Because healthcare.gov has become a trusted brand, facilitating other websites creates a cost wherein that brand is diluted and consumers may be directed to enroll through other websites that may not fit their needs. Whether it is because that website is not legitimate or because it does not display all the options available to a consumer, this does not serve their best interests.

Therefore, we urge CMS not to adopt the proposal for agents, brokers and issuers using their own websites to select their own third-party auditor. While we believe it is the role of CMS to audit and review websites for compliance with the consumer protections in the ACA, such as the §1557 non-discrimination requirements, at least requiring auditors to be reviewed and approved by HHS created an accountability mechanism. This proposal further muddies the waters in a space with too little oversight. We are also concerned that the proposed rule does not specify how CMS plans to ensure that the third-party auditors meet the standards proposed to be included in §155.221(b)(3) through (b)(8). This is underscored by the fact that we have heard from partners who have had clients who have been misled or confused by even legitimate online health insurance websites even under current rules. As such, CMS must take steps to ensure these websites are held to high standards.

The proposed rule also seeks general feedback on direct enrollment. We believe consumers are best served if they, at some point in the enrollment process, are directed through healthcare.gov. This ensures that they have healthcare.gov accounts that they can return to update life information, check for future open enrollments and to ensure consumers are checked for eligibility for Medicaid, CHIP and other public programs. We are particularly concerned that consumers may direct enroll through QHP websites. An underlying principle of the ACA is that competition and consumer choice would create healthy marketplaces. Consumers, particularly those who are low-information, may be directed to enroll in a QHP website without knowing there are other options available that may better suit their needs. They may even be directed to products that do not comply with ACA standards, such as short term insurance. As HHS has stepped back from advertising information about open enrollment, twice as many consumers report seeing ads for individual insurance products compared to ads for how to get covered under the ACA.[15] Thus, we strongly urge CMS to step back from its path of opening greater and greater access to direct enrollment with little oversight and instead ensure consumers have access to all the options open to them.

§ 155.305 – Eligibility Standards

We urge CMS to not adopt the proposal to eliminate the requirement that exchanges must notify consumers that they are ineligible for advanced premium tax credits (APTC). We have already heard from partners engaged in open enrollment for 2018 that have seen numerous consumers come in and be surprised about their ineligibility for APTC due to their failure to reconcile. Because open enrollment is already shortened, we fear consumers who wish to reconcile will lack the time to file and correct the situation. If this proposal is adopted, we expect even more consumers will fail to take action ahead of open enrollment to reconcile. This likely will place a further burden on groups performing enrollment work.

The draft rule states that CMS believes other notifications are sufficient to warn consumers that they need to reconcile and that IRS privacy rules make it difficult for exchanges to issue the notifications. We believe this does not justify placing a new burden on consumers. Instead, exchanges and CMS should work with IRS to develop systems that, while continuing to adhere to privacy requirements, allow these notices to be sent. We find the stated justification of canceling the notice strange because the notice has been generated for this enrollment period already, and therefore there are already systems in existence that allow coordination between IRS and exchanges. This is the only notice that specifically informs consumers that their ineligibility stems

[15] Kirzinger, Ashley et al, *Kaiser Health Tracking Poll – October 2017: Experiences of the Non-Group Marketplace Enrollees*, Kaiser Family Foundation, October 18 2017. Available at: https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-october-2017-experiences-of-the-non-group-marketplace-enrollees/

from their failure to reconcile and provides specificity for consumers may be confused by broadness of other notices. In particular, AA and NHPI LEP consumers often miss notices because they are unable to read them as notices are only provided in English and Spanish. When they do become aware of the notice, they often take the notice to an enrollment assister who helps them take the necessary steps to follow up. Allowing assisters in this situation to understand exactly why consumers are not eligible for APTC allows them to more effectively serve consumers needing assistance.

§ 155.320 – Verification Process Related to Eligibility for Insurance Affordability Programs

We urge CMS not to adopt new stricter verification requirements on consumers who attest to an income higher than 100% of the federal poverty level (FPL) if their attested income is higher than their return data indicates. This is a particularly vulnerable population who experience frequent changes in employment status, housing and household makeup. It would be worthwhile for CMS to put further resources into outreach and education to ensure consumers keep their income and other information up to date.

We have seen that data verification systems, including systems for verifying income, citizenship and identify, all have serious flaws and can tie consumers up trying to produce the required documentation. For example, while 26 million Americans lack a credit history, including 30 percent of consumers in low-income neighborhoods, healthcare.gov relies on credit score providers in part to verify income.[16] Workers in this income range experience shifts in employment status or position, and may change jobs or have experienced recent unemployment year to year or even month to month. Therefore, it is exceedingly likely that a significant number of consumers will be forced to verify income under this proposal, a burden for many time and resource strapped families. It is likely that many may either miss the information that they need to take further action or simply be unable to find the time to verify their income, such as those in cash-based industries who work erratic hours, and ultimately lose their health insurance. For example, 43.8 percent of households whose incomes very a lot month to month were un- or underbanked, meaning they likely would face significant challenges in verifying their income.[17] Our enrollment assister partners serve predominately low-income populations, and those consumers that do go through verification will likely turn to their assistance, placing yet another burden on these community organizations. For example, one partner estimates that 20% of their clients are in a situation that would require additional verification under this proposal.

§ 155.430 – Effective Dates for Termination

We support CMS's proposal to eliminate the option to require consumers to wait up to 14 days to effectuate termination of their coverage after giving notice. Removing this barrier gives consumers more flexibility to avoid paying unnecessary premiums, particularly for consumers who may wish to terminate coverage because of cash flow problems.

---

[16] Brevoort, Kenneth, *Data Point: Credit Invisibles*, Consumer Financial Protection Bureau, May 2015. Available at: files.consumerfinance.gov/f/201505_cfpb_data-point-credit-invisibles.pdf

[17] *2015 FDIC National Survey of Unbanked and Underbanked Households*, Federal Deposit Insurance Corporation, 2015. Available at: https://www.economicinclusion.gov/surveys/2015household/documents/2015_FDIC_Unbanked_HH_Survey_Report.pdf

We support, with caution, elimination of requirements that coverage must be terminated automatically the day-before-determination of eligibility for CHIP or Medicaid, at least as an option for states that find such a change would be beneficial based on their CHIP and Medicaid eligibility processes. As noted in the proposed rule, it is helpful to reduce circumstances where consumers are less exposed to surprise bills from providers whose payments for services in the time may be revoked, which would require the consumer to navigate potentially complicated process of getting those services paid for under their new coverage. Consumers who are LEP or have low health literacy may struggle to resolve these situations. However, consumers may need significant support in taking the step to terminate coverage, particularly because there may be a gap between when they are determined eligible for CHIP or Medicaid and when they are informed of their new eligibility. While there would be less concern about gaps due to processing time, due to the above-noted change eliminating the 14-day rule, they may lack the resources and knowledge for understanding that their old coverage is no longer automatically terminated. Specific outreach, either through the exchange or the Medicaid office should be required, and should be offered in-language.

We support state-by-state flexibility on adoption of this policy, allowing states to determine how this change would impact their populations, given their Medicaid eligibility processing times and when coverage is returned to, as well as their ability to reach and inform consumers about their need to take action. For example, in a state with strong consumer outreach in its exchange and Medicaid programs, where a consumer could be assisted through making the decision about when to set termination of coverage, this would be a logical policy.

§ 156.235 – Essential Community Providers

We oppose continuation of the lowered 20 percent threshold for plans' inclusion of essential community providers (ECP) and urge CMS to return it to at least the 30 percent level. Enrollee access to ECPs is critical to ensuring both their access to providers of their choice and to maintaining the provider infrastructure that makes up the bedrock of many communities. Many AA and NHPI communities face disparities in access to health care and health care outcomes. For example AAs are less likely to report that their doctors asked them about mental health and lifestyle issues and feel that their doctors spend less time with them than the general population.[18] ECPs ensure a diversity of providers are available to QHP customers, including to previously uninsured or previously Medicaid eligible individuals who have an existing relationship with them.

We also urge CMS to establish a better public understanding of why some issuers have been unable to meet the original 30% threshold. Currently, the narratives issuers must submit to explain why they were unable to meet the threshold are not publically available, which limits opportunity to address this ongoing issue. For example, we oppose the continuation of the option to write-in ECPs that are not on the HHS-sourced list of approved providers because it is unclear why such ECPs are not on this list. However, because ECPs typically lack the billing and administrative resources of bigger providers, it is possible that many are simply unable to fill out the papers needed to join the list. It may also be the case that smaller ECPs lack experience contracting with insurance companies. As CMS stated in its final 2017 Patient Protection and Affordable Care Act; Market Stabilization rule, only six percent of issuers were unable to meet the 30 percent standard.[19] Such a

[18] Ngo-Metzger, Q., Legedza, A. T. R., & Phillips, R. S.. *Asian Americans' Reports of Their Health Care Experiences: Results of a National Survey*. Journal of General Internal Medicine, *19*(2), 111–119, 2004. Available at: http://doi.org/10.1111/j.1525-1497.2004.30143.x

[19] 45 CFR Parts 147, 155, and 156

small number of providers indicates that reducing the threshold does not result in a substantial reduction of burden but simply avoids addressing a potentially greater problem. Instead of simply reverting to this lower standard, we urge CMS to study why some issuers find it difficult to contract with ECPs and determine what technical assistance CMS can provide to alleviate these problems.

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.

Thank you for the opportunity to comment on this proposed rule. Please do not hesitate to contact Isha Weerasinghe, Director of Policy and Advocacy (isha@aapcho.org), if you have any questions.

Sincerely,

Isha Weerasinghe, MSc
Director of Policy and Advocacy