September 28, 2011

Donald M. Berwick, MD, MPP
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9989-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Ref: CMS-9989-P

Re: Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans

Dear Dr. Berwick,

Catholic Health Initiatives (CHI) is pleased to provide comment on the establishment of exchanges and qualified health plans. CHI is a faith-based, mission-driven health system that includes 73 hospitals; 40 long-term care, assisted living, and residential units; two community health services organizations; and numerous physician practices and home health services across 19 states.

As a key component of the Affordable Care Act, state health insurance exchanges and the qualified health plans (QHPs) that will be offered through the exchanges are critical building blocks of a future where everyone has access to health care providers and coverage for health care services. Access and coverage for all has been a top priority for CHI for many years. We applaud CMS for the steps it has taken in this proposed rule to move that vision forward.

We particularly are pleased that CMS has taken the approach to give states as much flexibility as possible to create the most appropriate exchanges for their unique circumstances. With states having such diverse populations, different economies and varying geographies, it would be impractical to expect a “one size fits all” approach to work well. We commend CMS for understanding that state insurance regulators and exchange governing boards will have the best understanding of state insurance needs.

We offer the following recommendations on key elements of the proposed rule.
Certification of Qualified Health Plans

CMS is proposing to provide maximum flexibility to states in determining which QHPs can be certified and offered on the exchange. While we agree with the concept of flexibility, we urge CMS to encourage states to be open to new types of health plan offerings, new types of health plans, and new models of care. Similarly, we ask CMS to encourage states to err on the side of inclusion, rather than exclusion, when creating rules for certifying health plans for sale on the exchange. We believe the market should be allowed to operate and develop organically, with opportunity for new and innovative insurance products to enter the market.

Healthcare delivery is changing rapidly, even more so with the enactment of the Affordable Care Act. We do not know yet what types of insurance plans will be needed or offered in the coming years. Current insurers, new entrants to the insurance market, and provider-sponsored health plans should have an incentive to create innovative health insurance options for consumers. Flexible and inclusionary QHP certification policies will help encourage innovation in insurance product development. In addition, CMS should encourage states to allow new entrants to the insurance markets to join the exchange on a regular basis.

Recommendation: CMS should encourage states to offer maximum flexibility to allow new and innovative insurance products to enter, qualify, and participate in an exchange. CMS should encourage states to be inclusionary rather than exclusionary when creating rules for certification of qualified health plans.

Provider Network Adequacy Standards

CMS seeks guidance related to provider network adequacy standards, particularly if the agency should establish additional minimum qualitative or quantitative standards for the exchange to use in evaluation of whether a QHP provider network provides sufficient access to care. Additionally, CMS asks if a model developed by the National Association of Insurance Commissioners is a useful standard, or if CMS should set requirements for adequate provider networks in medically underserved or remote rural areas.

CHI defers again to the prevailing concept of state flexibility in our response. We believe CMS should not establish additional federal standards for network adequacy. Those decisions should be left to states, exchange governing boards, and consumers. CHI believes that consumers should have choices in the plans they select, and plans should have choices in the offerings they propose.
State insurance regulators and exchange governing boards should be given flexibility to determine how best to assure coverage and choices for consumers in medically underserved areas, as well. State approaches may need to vary depending on the effectiveness of the market in generating plans with coverage in underserved areas. Exchanges may need to provide incentives, set additional requirements, or seek bids depending on their circumstances. We believe that if CMS gives states the flexibility to create their own network adequacy standards, state lawmakers and regulators and exchange governing boards will be in the best position to ensure all regions of the state have adequate access to health care services.

However, we do believe that exchanges must assure that there is a safety net for plan participants in medically underserved areas that allow participants to obtain care outside of a plan’s network if needed services (e.g., specialists, cancer treatment) are not available in the local network.

**Recommendation:** CMS should leave the task of determining network adequacy standards to state lawmakers, state regulators, and exchange governing boards. However, CMS should require states to ensure that consumers who live in medically underserved or rural areas have access to necessary care outside of their plan’s network when it is not available within their network.

In the proposed rule, CMS recognizes the challenge of primary care access in many communities and encourages states, exchanges, and health insurance issuers to consider broadly defining the types of providers that furnish primary care services (e.g., nurse practitioners, physician assistants). Since state law varies regarding what types of practitioners can provide primary care services, we believe CMS could go even farther by encouraging states to broaden their scope of practice laws to encourage the most flexibility possible. CMS could create model scope of practice guidelines for states to refer to when examining their own laws.

In addition, CMS should strongly encourage state exchanges to seek creative approaches to addressing the shortage of primary care providers. Exchanges and plans will need to allow for creativity and new models of primary care delivery to address the shortage of physicians and practitioners.

**Recommendation:** CMS should strongly encourage states to define primary care providers as broadly as is allowable under state law. CMS also should ask states to expand their scope of practice laws. Finally, CMS should encourage exchanges to allow for creativity and new models of primary care delivery to address the shortage of physicians and practitioners.
Inclusion of Essential Community Providers in Networks

The Affordable Care Act requires inclusion of essential community providers in QHP networks. In the proposed regulation, CMS states that the law does not require QHP issuers to contract with all essential community providers. The proposed rule requires a health plan issuer to include in its provider network a “sufficient number of essential community providers, where available, that serve predominantly low-income, medically underserved individuals.”

CHI commends CMS for the flexible approach it has taken in this section of the proposed rule. We believe that CMS does not need to define “sufficient” and should not mandate inclusions of specific provider categories. State regulators and exchange governing boards are in the best position to identify local needs and resources and to determine the appropriate inclusions of essential community providers in QHPs.

However, CHI also notes that essential community providers are, in fact, essential to the health of their communities. While a mandate to include all such providers would go too far, we urge CMS to encourage state regulators and exchange governing bodies to adopt an inclusionary viewpoint that promotes contracting with a diverse array of essential community providers.

Recommendation: CMS should not mandate the number of essential community providers necessary to reach a “sufficient number of essential community providers.” That requirement should be left to state regulators and exchange governing boards. However, CMS should strongly encourage state regulators and exchange governing boards to include a diverse array of providers when determining the definition of “sufficient.”

Governance

The proposed rule sets minimal requirements for the governing boards of exchanges that are set up as independent state agencies or non-profits established by the state. The proposed requirements assert that boards may not have a majority of voting members with a conflict of interest.

CHI believes that one important group was left off the list of individuals who may have a potential conflict of interest. We believe health information technology companies, particularly those with a financial interest in the hardware and software that will run the operations of an exchange, should be counted among those with a conflict of interest.

Recommendation: CMS should add “health information technology companies” as a group that may have a conflict of interest in the governance of the exchange.
The proposed rules declares that boards must have a majority of voting members with specified relevant experience, specifically health benefits administration, health finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured. While this list is excellent, CHI believes two groups have been under-represented.

CHI urges CMS to require clinician representation on the governing bodies of the exchanges. Physicians, nurses and other clinicians are closest to the patients and their health needs and will have insights on how the exchange and the plans are working for consumers. Additionally, CMS should require patient representation on the board of the exchange.

**Recommendation: CMS should include clinicians and patients, or those representing their interests, to the list of governing board members for the exchanges.**

**Stakeholder Input**

The Affordable Care Act requires exchanges to consult with stakeholders on an ongoing basis. The Act specifically identifies as stakeholders: educated health consumers enrolled in QHPs, individuals/entities with experience in health insurance enrollment facilitation, advocates for enrolling hard-to-reach populations such as individuals with a mental health or substance abuse disorder, small business and self-employed individuals, and state Medicaid agencies. The proposed rule adds additional stakeholders who must be consulted, including federally-recognized tribes, public health experts, health care providers, large employers, health insurance issuers, and agents and brokers.

This list is quite comprehensive, but we believe it needs some clarification and expansion. We urge CMS to emphasize that when seeking input from “health care providers,” the exchanges should include providers from the full continuum of care (hospitals, physicians, home health, skilled nursing facilities, etc.) to assure understanding of all facets of health care delivery and the interrelationship of various components in new models of health care delivery and payment. We also ask CMS to emphasize that stakeholders should represent a geographically diverse viewpoint, including urban and rural representation.

**Recommendation: CMS should emphasize the need for provider input from the full continuum of care, as well as the need for input from all regions of a state, including rural and urban input.**
CHI is pleased to have the opportunity to provide input on the proposed regulation implementing this important piece of the Affordable Care Act. If you would like additional information, please contact Colleen Scanlon, Sr. Vice President of Advocacy, at 303-383-2693.

Sincerely,

Kevin E. Lofton
President and CEO