ACAP
Association for Community Affiliated Plans

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October 31, 2011

Dr. Donald M. Berwick
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244
File code: CMS–9989–P

Submitted electronically via: *http://www.regulations.gov*

Dear Dr. Berwick:

The Association for Community Affiliated Plans (ACAP) very much appreciates this opportunity to provide comments to the Center for Consumer Information and Insurance Oversight (CCIIO) in response to the proposed rule called *Establishment of Exchanges and Qualified Health Plans* (CMS-9989-P, 76 Fed. Reg. 41866 (July 15, 2011)) of the Patient Protection and Affordable Care Act, enacted on March 23, 2010.[1]

ACAP is an association of 59 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 28 states.[2] Our member plans provide coverage to 9 million individuals enrolled in Medicaid, Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans for dual eligibles. Nationally, ACAP plans serve approximately one-third of all Medicaid managed care enrollees. Safety Net Health Plans currently are developing plans to serve those individuals that will gain new coverage due to insurance expansions enacted by the Affordable Care Act; such plans must be viewed as full partners in meeting the coverage needs of our nation's low-income health care consumers – whether they are eligible for Medicaid, CHIP, coverage in health state-based health insurance Exchanges, or other health care programs.

ACAP is limiting our comments primarily to issues that are of particular importance to Safety Net Health Plans as they strive to support the implementation of the Affordable Care Act. We also have attached, incorporate and (where, we believe, particularly relevant to our comments herein) reiterate the comments we submitted to HHS on January 11, 2011 outlining basic requirements for plan participation in Medicaid, the Exchange, and commercial coverage, and on October 4, 2010 in response to its request for comments regarding the Exchange Related Provisions in the Affordable

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[1] The Patient Protection and Affordable Care Act (P.L. 111-148) and the Healthcare and Education Reconciliation Act (P.L. 111-152) together are referred to in this letter as the Affordable Care Act.

[2] ACAP represents safety net health plans that are exempt from federal income tax, or that are owned by an entity or entities exempt from federal income tax, and in which no less than 75 percent of the enrolled population receives benefits under a Federal health care program as defined in section 1128B(f)(1) (42 USC 1320a-7b(f)(1)) or a health care plan or program which is funded, in whole or in part, by a State or locality (other than a program for government employees).

Care Act. We respectfully urge you to consider the following comments that will help to ensure that low-income health care consumers are well-served by the Exchanges and qualified health plans. A summary of our comments follows here:

1. ACAP strongly supports allowing the Exchange to administer premiums, encourages HHS to promote this practice among state Exchanges, and recommends that the federal Exchange also administer premiums.
2. ACAP urges HHS to consider a series of recommendations related to Navigators, agents and brokers.
3. ACAP strongly supports the existence of a special enrollment period for individuals who lose Medicaid coverage and suggests that individuals should be automatically and immediately enrolled in a qualified health plan in the Exchange so that they do not experience a gap in coverage or care. We also recommend that HHS allow Exchanges to certify as licensed those Medicaid health plans with enrollees who become eligible for the Exchange due to an increase of income.
4. Regarding qualification of health plans to serve the Exchange, ACAP asks HHS to:
    a. Require states to implement a five-year transitional period (until 2019) for Safety Net Health Plans to build required reserves.
    b. Provide a transitional period until 2017 for all health plans that are not currently accredited to obtain the required accreditation for plan participation.
    c. Avoid requiring all qualified health plans to be accredited by one particular entity, and instead to allow plans to choose which accreditor to use.
    d. Adapt existing Medicaid MCO access and quality requirements as a basis for standards for qualified health plans serving the Exchange.
    e. Ensure that grievance and appeals requirements for health plans are consistent for all health plans serving the Exchange and are simple to administer.
    f. Allow Medicaid health plans to be given a period of not fewer than two years to gain licensure.
    g. Allow Exchanges to certify as licensed those Medicaid and CHIP health plans with enrollees who move into the Exchange and which cover families with split eligibility for the purpose of continuing to cover those individuals and families only.
    h. Prohibit states from requiring all Medicaid health plans to serve the Exchange, and from requiring all Exchange plans to serve Medicaid.
5. ACAP strongly supports the requirement that all qualified health plans contract with essential community providers.
6. Regarding payment from qualified health plans to federally qualified health centers (FQHCs), ACAP requests HHS to
    a. Allow Exchanges to employ what in the Medicaid program is called a "wrap-around" system of payment.
    b. Account in any risk adjustment methodology for the proportion of a plan's network comprising providers that serve higher risk populations, such as community health centers, hospital based clinics, and others.
    c. Undertake a study to compare current Medicaid PPS rates for FQHCs and rates paid for primary care services provided in other settings; to study the value of the PPS payment system by quantifying the overall annual cost of services utilized by patients served by FQHCs versus the overall annual cost of services utilized by patients

served in other primary care settings; and to examine the impact of PPS on the competitiveness of qualified health plans

7. ACAP supports the provision of the draft rule that allows plans to serve a single county, and asks that the federal Exchange also allow qualified health plans to maintain a county-sized service area as well. Should a state Exchange require qualified health plans to maintain service areas larger than a single county, ACAP requests HHS to require every Exchange to allow Safety Net Health Plans to serve a single county.

II. Provisions of the Proposed Regulation

Part 155, Subpart C – General Functions of an Exchange, a. Functions of an Exchange

In this Subpart, which outlines the minimum functions of an exchange, HHS codifies various functions the Exchange must perform, including eligibility determinations for coverage through a qualified health plan, premium tax credits and cost-sharing reductions, determinations of exemptions from the individual mandate, establishment of an eligibility appeals process, and various other functions.

In paragraph (d), HHS proposes to allow an Exchange to facilitate through electronic means the collection and payment of premiums. HHS writes

> "While we do not require or limit the methods of premium payment in connection with individual market coverage, we note that an Exchange generally has three options: (1) Take no part in payment of premiums, which means that enrollees must pay premiums directly to a QHP issuer; (2) facilitate the payment of premiums by enrollees by creating an electronic "pass-through" of premiums without directly retaining any of the payments; or (3) establish a payment option where the Exchange collects premiums from enrollees and pays an aggregated sum to the QHP issuers.

The preamble notes that an Exchange could act as a simple pass-through or the Exchange collecting and distributing premiums to QHP issuers.

Medicaid health plans that have not sold insurance in the individual or group markets often do not have experience in collecting premiums from policy holders, and therefore would have to quickly build the capacity to do so if an Exchange were to require qualified health plans to administer the premium function. ACAP recognizes that in the Exchange, the premium collection function may be complicated for qualified health plans by the fact that premium tax credits will augment individual premium payments, and that these amounts may vary throughout the year depending on an individual's changing income.

> Because ACAP strives to reduce barriers for participation by Medicaid health plans in the Exchange for the purpose of ensuring that low-income health care consumers are well-served, and because many Medicaid health plans may not currently have the capacity to collect premiums, **ACAP strongly supports allowing the Exchange to administer premiums, and encourages HHS to promote this practice among state Exchanges.**

ACAP recommends that the federal Exchange also administer premiums.

Part 155, Subpart C, c. Navigator Program Standards, and d. Ability of States to Permit Agents and Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in Qualified Health Plans

These sections of the proposed rule establish standards for the Navigator Program and establish permission for states to permit agents or brokers to assist individuals enrolling in qualified health plans through the Exchange, respectively.

ACAP recognizes the value of brokers and agents to health coverage, and is aware that policies impacting the use of brokers and agents differ from state to state and market to market. ACAP Safety Net Health Plans anticipate serving a lower-income and higher-needs population in the Exchange to expand upon their missions of working with low-income enrollees of Medicaid and CHIP. These plans expect to benefit from the community-based education and outreach activities provided by community-based organizations, including those serving the Navigator program. Some ACAP plans intend to use the services of brokers and agents when the Exchanges are operational, although it is uncertain whether all will.

For these reasons, ACAP recommends that HHS take the following approaches with the Navigator Program and Agents and Brokers. Exchanges should:

- **Require that agents and brokers be paid the same** amounts inside and outside of Exchange and regardless of which plan a consumer chooses.
- **Require that payments to brokers and agents be transparent.** If information related to brokers and agents is included on an Exchange's website, the website should also display information on broker and agent fees.
- **Implement a system that pays brokers and agents a flat fee.** Although brokers and agents currently are paid a percentage of premiums, ACAP believes that incentives to steer patients to expensive plans will be mitigated if brokers and agents be paid a flat fee.
- **Provide qualified health plans with a choice** regarding:
    - Whether to use brokers and agents.
    - Which brokers and agents to use.
- **Require brokers and agents to charge qualified health plans directly *only* when a broker or agent sells that particular qualified health plan to a consumer.** If no broker or agent sells the qualified health plan (i.e., the plan is purchased directly by the consumer), the plan should not be charged.
- **Include costs related to administering the Navigator grants program** in the Exchange's overhead.
- **Exclude broker and agent fees** from the Exchange's overhead.
- **Not require Navigators to be licensed as brokers or agents.** However, ACAP believes that all brokers, agents and Navigators should be required to meet high standards so that all consumers working with any of these entities are provided with accurate, timely and unbiased information regarding health coverage through the Exchange.

ACAP urges HHS to implement these recommendations for the federal Exchange as well.

Part 155, Subpart E, d. Special Enrollment Periods

The preamble of the proposed rule indicates that in accordance with section 1311(c)(6)(C) of the Affordable Care Act, the Secretary must establish special enrollment periods. The special enrollment periods described in the draft rule would permit a qualified individual and any dependents to enroll in a qualified health plan due to loss of minimum essential coverage. Elsewhere in the proposed rule it is noted that minimum essential coverage includes Medicaid and CHIP.

Other special enrollment periods include loss of eligibility for Medicare, and a change in eligibility for advanced premium tax credits or cost-sharing reductions, regardless of whether an individual is already enrolled in a QHP.

ACAP strongly supports the existence of a special enrollment period for individuals who lose Medicaid coverage. We believe that these individuals should be automatically and immediately enrolled in a qualified health plan in the Exchange so that they do not experience a gap in coverage or care. Furthermore, to ensure continuity of coverage and care, ACAP recommends that HHS allow Exchanges to certify as licensed those Medicaid health plans with enrollees who become eligible for the Exchange due to an increase of income. These individuals could be offered an "opt-out" (Please see ACAP's recommendations to Part 155, Subpart K – Certification Standards for Qualified Health Plans, 5. Licensing.)

Part 155, Subpart K – Certification Standards for Qualified Health Plans

In the preamble to the draft rule, HHS proposes to codify section 1311(e)(1)(B) of the Affordable Care Act, which allows an Exchange to certify a health plan if it determines it is in the interest of qualified individuals and qualified employers in the State. The preamble notes that HHS intends to "provide Exchanges with discretion on how to determine whether offering health plans is in the interest of individuals and employers."

Data demonstrate the high volume of income volatility among people with incomes below 200 percent of the federal poverty level. In the absence of a continuous eligibility policy for adults in all but one state Medicaid program (New York will implement 12-month continuous eligibility for adults in February 2012 as part of an 1115 waiver), many lower-income Medicaid and Exchange enrollees will experience changes in eligibility between Medicaid and the Exchange. In addition, many families will experience "split eligibility," with children covered by Medicaid or CHIP and parents covered by qualified health plans in the Exchange. Estimates from the Urban Institute indicate that three out of four parents who are eligible for the Exchange will have one or more children who are eligible for CHIP or Medicaid and must enroll in these programs.

For both of these reasons, ACAP wishes to note the importance of having Safety Net Health Plans and other Medicaid health plans serve the Exchange. In a letter to Joel Ario dated January 11, 2011, ACAP previously identified several policy solutions to reduce barriers to participation by Safety Net and other Medicaid health plans in the Exchange.

In this letter, we reiterate most of those recommendations and modify our recommendations regarding licensure to ensure continuity of coverage and access to providers for low-income people who experience eligibility "churn" between programs.

1. **Reserves & Solvency Requirements**

   Exchange guidance should indicate that states must implement a five-year transitional period (until 2019) for Safety Net Health Plans to build required reserves. For this policy, HHS should employ the definition of safety net health plan appearing in the Affordable Care Act at section 9010(c)(2). The section provides an exemption from the health insurer fee for health plans that are nonprofit and derive 80 percent of revenues from Medicare, Medicaid and CHIP. During the transition period, Safety Net Health Plans would be required to meet benchmark solvency requirements.

   Reserve requirements will be a substantial barrier for nonprofit Safety Net Health Plans to participate in the Exchange. Unlike for profit plans, safety net health plans do not have the opportunity to raise capital. However, it is critically important that Safety Net Plans have an opportunity to serve Exchange enrollees who are low-income and otherwise vulnerable, as these individuals are dissimilar to the existing commercial population and will require special services and expertise that Safety Net Health Plans have developed during years of supporting Medicaid programs.

   There is precedent for a phase-in of solvency requirements. The State of New York currently is in the process of phasing in increasingly stringent solvency requirements for certain health plans serving the New York Medicaid program.

   ACAP also recommends that the federal Exchange provide for a five-year transitional period to allow Safety Net Health Plans to build reserves.

2. **Accreditation**

   The proposed rule addresses accreditation requirements for qualified health plans at Subpart K, paragraph e.

   Because immediate accreditation may be a substantial barrier to participation by Medicaid health plans (including Safety Net Health Plans) in the Exchange, ACAP previously recommended that **Exchange rules should allow the Exchange to establish a transitional period until 2017 for all health plans that are not currently accredited to obtain the required accreditation for plan participation.** To prepare for Exchange

participation in 2014, health plans which are not currently accredited would conceivably have to start the accreditation process now, prior to having sufficient knowledge about the Exchange to have determined whether to participate. Twenty-five of ACAP's 59 Safety Net Health Plan members are either currently accredited or are in progress to be accredited by URAC, AAAHC or NCQA. However, we recognize that federal guidance that explicitly allows a reasonable time period for plans to become accredited will allow a greater cross-section of health plans to participate, including many plans that already serve the Medicaid program.

The draft rule codifies the statutory requirement that the Exchange must establish a uniform period following certification of a qualified health plan within which the plan must become accredited, and provides that "a grace period may be necessary since ... accreditation process may take twelve to eighteen months to complete." ACAP strongly supports this position.

In addition, **ACAP urges HHS to avoid requiring all qualified health plans to be accredited by one particular entity, and instead to allow plans to choose which accreditor to use.** Furthermore, HHS should deem the accrediting entities as soon as possible to provide states and plans with clarity regarding requirements for qualified health plans.

ACAP submits these recommendations for the federal Exchange as well as state-based Exchanges.

3. **Quality**

ACAP recognizes that HHS will address quality requirements in detail in a later draft rule. In the meantime, **we reiterate our January 2011 recommendation that Exchange guidance adapt existing Medicaid MCO access and quality requirements as a basis for standards for qualified health plans serving the Exchange.** Medicaid MCO access and quality requirements specifically address the needs of managed care enrollees who are low-income or have special cultural or health care needs, to an equal or greater extent than requirements applicable to Medicare and private sector MCOs. Neither Medicare nor private sector requirements specifically address the needs of low-income individuals as distinct from those of other enrollees.

In addition, quality scoring conventions should take into consideration the population served by each health plan so that plans serving a larger proportion of higher-needs and vulnerable individuals are not unfairly penalized. Income data for many Exchange enrollees will be available to the Exchange because of eligibility determinations for premium tax credits and cost-sharing reductions; ACAP suggests that these data be used to stratify quality scores as well.

4. **Grievances & Appeals**

Exchange rules should ensure that grievance and appeals requirements for health plans are consistent for all health plans serving the Exchange and are simple to

administer. For example, health plans that currently serve a Medicaid program should implement the Exchange standards for grievances and appeals related to all Exchange enrollees, rather than utilize the Medicaid standard. Such plans would still adhere to the Medicaid grievance and appeals policies for enrollees in that program.

5. **Licensing**

Previously, ACAP requested that HHS codify qualified health plan licensure requirements in such a way to require states to consider licensed as a qualified health plan for the purpose of offering coverage in the Exchange in that state any plan that is currently licensed to participate in the Medicaid program by the state Department of Insurance, state Medicaid agency, or a separate state licensing entity. This would leverage existing infrastructure and resources thereby minimizing burden on plans and states.

ACAP urges HHS to allow Medicaid health plans to be given a period of not fewer than two years to gain licensure, providing each state Department of Insurance with an opportunity to conduct audits for provisional licensure while the health plans undergo the licensing process.

Furthermore, with a particular interest in the coverage needs of low-income individuals who can be anticipated to experience income changes that alter their eligibility between Medicaid and the Exchange as well as families that have members who are eligible for different programs, as noted earlier in this letter, **ACAP recommends that HHS allow Exchanges to certify as licensed those Medicaid and CHIP health plans with enrollees who move into the Exchange and which cover families with split eligibility for the purpose of continuing to cover those individuals and families only.** Individuals and families could be offered an "opt-out" if they choose to select a different plan in the Exchange rather than remain with their Medicaid or CHIP plan. If the plan wishes to seek certification as a qualified health plan to serve "all-comers" in the Exchange, the plan can do so by meeting the requirements of that Exchange.

In our October 2010 letter, we wrote that the Massachusetts health reform experience demonstrates that individuals transitioning between the Exchange and Medicaid and CHIP and families with split eligibility will need assistance navigating the choices and identifying the best option for them. These solutions will ensure continuity of coverage for low-income enrollees who churn, will allow split families to remain in the same health plan, and will ensure participation by Medicaid health plans in the Exchange for the purpose of serving those individuals and families.

Lastly, **ACAP urges HHS to prohibit states from requiring all Medicaid health plans to serve the Exchange, and from requiring all Exchange plans to serve Medicaid.** A recently-published report by the Kaiser Family Foundation titled *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey* (http://www.kff.org/medicaid/8220.cfm) indicates that eight states are considering requiring Medicaid plans to serve the Exchange. Because other barriers to serving the Exchange exist for Safety Net Health Plans, including reserves and accreditation rules, such a requirement could present some mission-based plans

with an obligation they cannot fulfill. In 2014, these plans will also face an expansion of the Medicaid program to approximately 16 million new individuals nationally. Most Safety Net Health Plans currently serve only Medicaid and CHIP; if they are required to serve the Exchange to maintain a Medicaid presence but find they are unable to do so, these plans could be put out of business entirely, causing substantial disruption for Medicaid programs and enrollees. The Kaiser report also notes that seven states are considering requiring Exchange plans to serve Medicaid; this requirement could distort the Medicaid market by disadvantaging smaller, local, nonprofit and mission-oriented health plans, and may similarly cause disruption for Medicaid enrollees.

While ACAP strives to ensure that Safety Net Health Plans are able to serve the Exchanges, we recommend against requiring that Medicaid health plans serve the Exchange, and qualified health plans serve Medicaid.

Part 155, Subpart K, f. Establishment of Exchange Network Adequacy Standards, and Part 156, Subpart C, e. Network Adequacy Standards and f. Essential Community Providers

The preamble of the proposed rule states that under the Affordable Care Act (in part 155, subpart K), HHS is required to establish network adequacy requirements for health insurance issuers seeking certification of qualified health plans. The preamble indicates that HHS recognizes the importance of geography, demographics, local patterns of care, and market conditions to network adequacy standards, and requires that the Exchange ensure that each qualified health plan offer a "sufficient choice of providers" for its enrollees.

In addition, section 1311(c)(1) requires that to be certified a plan shall, at a minimum—

> "(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act… ."

The preamble for this section indicates that networks must include a "sufficient number of essential community providers" which serve predominantly low-income, medically-underserved individuals.

Safety Net Health Plans have long been both formally and informally affiliated with essential community providers. We applaud HHS for recognizing the importance of these critical community health care providers in meeting the needs of high-needs and low-income individuals throughout the country. Essential community providers, which include but are not limited to those entities specified under section 340B (a)(4) of the Public Health Service Act, play a particularly critical role in the care of low-income and critically or chronically ill and disabled individuals who require a broad and diverse range of medical, habilitative and rehabilitative services throughout their lives. Currently through the Medicaid and CHIP programs, ACAP health plans serve a very high proportion of individuals at federally qualified health centers and other essential community providers, and we anticipate these relationships to remain firm as Safety Net Health Plans enter the Exchange as qualified health plans.

The preamble states that "although the Affordable Care Act requires inclusion of essential community providers in QHP networks, the Act does not require QHP issuers to contract with or offer contracts to all essential community providers," and explores whether such a requirement "may inhibit attempts to use network design to incentivize higher quality, cost effective care by tiering networks and driving volume towards providers that meet certain quality and value goals." Because cost and quality are also critical factors in ensuring that all Exchange consumers receive high-quality and affordable care, ACAP understands this reasoning. However, we believe that inclusion of safety net providers in all qualified health plans' networks will help diminish the chance for cherry-picking and will ensure that all high-risk or lower-income health care consumers are well-served, regardless of their choice of qualified health plan.

ACAP strongly supports the requirement that all qualified health plans contract with essential community providers.

Section 1302(g) of the Affordable Care Act requires that health plans qualified by state Exchanges to provide coverage to individuals and small businesses pay no less than the prospective payment system (PPS) rate required under section 1902(bb) of title XIX of the Social Security Act for services provided by FQHCs. This section of the Medicaid law requires Medicaid programs to pay FQHCs an amount calculated on a per-visit basis equal to the reasonable costs of services documented for a baseline period, with certain adjustments, or to use an approved alternative payment methodology. Each FQHC receives a unique PPS rate for Medicaid services, and currently little research exists comparing these rates to primary care rates paid to other providers in Medicaid, Medicare and commercial coverage.

In the preamble, HHS recognizes that

> "if FQHC Medicaid PPS rates are greater than comparable amounts paid to other providers, and if many of the enrollees in a QHP receive care at FQHCs, the costs of these QHPs may be greater than the costs of QHPs that do not have many enrollees who are seen at the centers. Also, if Medicaid prospective payment rates exceed QHPs' generally applicable payment rates, requiring QHP issuers to pay the full FQHC Medicaid PPS rate could lead insurers to minimally contract with FQHCs."

Furthermore, HHS recognizes practical considerations of requiring PPS methodology for payment to FQHCs serving the Exchange, including how to administer the facility-specific rate. HHS explores a number of options regarding FQHC payment, including permitting qualified health plan issuers to "negotiate mutually agreed-upon payment rates with FQHCs, as long as they are at least equal to the issuer's generally applicable payment rates." HHS writes that "such an interpretation may furnish FQHCs with a degree of negotiating leverage with issuers to obtain payment rates higher than the issuer's generally applicable payment rates but not tie issuers to the full Medicaid PPS rate for in-network FQHCs," and recognizes that "this approach would decrease the incentive to drive patients away from providers that may be best suited to their needs, while providing FQHCs with leverage to be able to negotiate payments that will allow them to continue providing the comprehensive services that are particularly valuable to the individuals they serve." It is noted that this option may also cause FQHCs to accept less than Medicaid PPS rates for services.

ACAP agrees with HHS that the PPS payment requirement in the Affordable Care Act is impacted by Section 1311(c)(1) of the Affordable Care Act, which requires qualified health plans to "include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals," including FQHCs, and specifically by section 1311(c)(2), which states that "nothing in paragraph (1)(C) shall be construed to require a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan."

Safety Net Health Plans are committed to working closely with FQHCs for the purpose of providing health care services to low-income and vulnerable consumers of health care, both within Exchanges and in the Medicaid program.

ACAP requests HHS to consider allowing Exchanges to employ what in the Medicaid program is called a "wrap-around" system of payment. This would permit qualified health plans to pay FQHCs what they would pay other providers for comparable services, and to, as CMS states in its preamble, negotiate payment with FQHCs "as long as they are at least equal to the issuer's generally applicable payment rates." However, the Exchange would also pay the FQHC the difference between the payment received from the qualified health plan and its facility-specific PPS payment. This approach would basically reflect the "wrap-around" payment methodology provided to FQHCs under the Medicaid statute described in Section 1902(bb) of the Social Security Act, which is referenced in full in Section 1302(g) of the Affordable Care Act. Such an approach may even the playing field between those health plans that contract with numerous FQHCs and those qualified health plans that do not, and may also equalize payments made by qualified health plans with large numbers of enrollees who utilize FQHCs for their care with payments made by those qualified health plans who do not. A possible approach may be to limit the lifespan of the wrap-around payment to qualified health plans to the first several years of the existence of the Exchange.

HHS must consider what the source of the wrap-around payment might be. One approach would be to fund the wrap-around payment by way of user fees that qualified health plans will pay to the Exchange. ACAP recommends that HHS study various options for crafting a wrap-around payment system that will best level the playing field for qualified health plans.

ACAP has also commented on the proposed rule Standards Related to Reinsurance, Risk Corridors and Risk Adjustment. Our comments include a recommendation that risk adjustment and other risk mitigation systems should include risk factors that are highly prevalent in lower-income populations, including diagnoses, including for mental health and substance abuse disorders, as well as income, language barriers, and other barriers for the populations that will be covered through the Exchange. **We strongly suggest that such systems must also account for the proportion of a plan's network comprising providers that serve higher risk populations, such as community health centers, hospital based clinics, and others.** As noted previously, many Safety Net Plans serve a high proportion of enrollees who receive health care services through community health centers. The cost for these services may well be higher than non-clinic providers because

the Affordable Care Act requires that FQHCs be reimbursed at PPS rates for Exchange products.

Lastly, because many Safety Net Health Plans are weighing the opportunities and risks of serving state Exchanges as qualified health plans and because the PPS payment requirement may be a deciding factor for some health plans, **ACAP recommends that HHS undertake a study to compare current Medicaid PPS rates for FQHCs and rates paid for primary care services provided in other settings.** Furthermore, **ACAP recommends that HHS study the value of the PPS payment system by quantifying the overall annual cost of services utilized by patients served by FQHCs versus the overall annual cost of services utilized by patients served in other primary care settings.** Past studies have demonstrated that patients receiving primary care services from an FQHC cost less over time than other patients. Finally, **we recommend that HHS examine the impact of PPS on the competitiveness of qualified health plans** to determine whether plans that contract disproportionately with FQHCs charge higher premium rates than other qualified health plans.

Part 155, Subpart K, g. Service Area of a Qualified Health Plan

In the preamble to this section, HHS proposes that the service area of a qualified health plan covers at least a county, or a group of counties defined by the Exchange, unless the Exchange determines that serving a smaller geographic area is necessary.

Safety Net Health Plans are mission-focused, community-based entities and often have a relatively small service area. In many cases, Safety Net Health Plans – such as the plans currently serving the California Medicaid program – serve a single county. For the reasons cited earlier in this letter, the participation of these plans in the Exchange is critical for the coverage of lower-income health care consumers in their communities.

ACAP supports the provision of the draft rule that allows plans to serve a single county. The federal Exchange also should allow qualified health plans to maintain a county-sized service area as well.

Should a state Exchange require qualified health plans to maintain service areas larger than a single county, ACAP requests HHS to require every Exchange to allow Safety Net Health Plans to serve a single county. For this policy, HHS should employ the definition of safety net health plan appearing in the Affordable Care Act at section 9010(c)(2). The section provides an exemption from the health insurer fee for health plans that are nonprofit and derive 80 percent of revenues from Medicare, Medicaid and CHIP.

We appreciate your consideration of our comments regarding Establishment of the Exchange and Qualified Health Plans. ACAP is prepared to assist the agency with additional information as needed. If you have any additional questions please do not hesitate to contact Jennifer Babcock at (202) 204-7518 or jbabcock@communityplans.net.

Sincerely,

Margaret A. Murray
Chief Executive Officer