ACAP
Association for Community Affiliated Plans

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John Lovelace, Chairman | Margaret A. Murray, Chief Executive Officer

December 21, 2015

Kevin Counihan, Chief Executive Officer
Center for Consumer Information and Insurance Oversight
Department of Health & Human Services
Submitted via Regulations.gov

Re: CMS-9937-P

Dear Mr. Counihan:

The Association for Community Affiliated Plans (ACAP) respectfully submits comments regarding HHS Notice of Benefit and Payment Parameters for 2017: Proposed Rule.

ACAP is an association of 60 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 24 states. Our member plans provide coverage to approximately 12 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans for dually-eligible individuals. Nationally, ACAP plans serve roughly one-third of all Medicaid managed care enrollees. Seventeen of ACAP's Safety Net Health Plan members have elected to offer qualified health plans (QHPs) in the Exchanges in 2016.

Summary of ACAP's Comments

Please find below a list of ACAP's comments. ACAP has chosen to respond to a subset of proposals in the draft Notice that are particularly relevant to Safety Net Health Plans, rather than to the entire rule. ACAP is supportive of numerous provisions throughout the rule and appreciates CCIIO's continued willingness to evaluate whether specific programs and provisions are working as intended and update them accordingly. In particular, we appreciate CCIIO's continued focus on ensuring the Exchanges work for low-income and vulnerable populations—exactly the population with the most to gain from establishment of the Exchanges and exactly the population served by Safety Net Health Plans. ACAP would like to urge caution as the Exchanges continue to stabilize, so that Safety Net Health Plans retain sufficient flexibility to be able to best serve the individuals and families in their service areas, which they are generally well-acquainted to by way of their Medicaid offerings in the same area.

The positions summarized below are explained in greater detail later in the letter.

- **Standardized Plan Options.** ACAP supports CMS' desire to simplify and improve plan choice for consumers, however, we oppose the standardized plan options set out in the draft Notice. ACAP recommends, instead, that CMS further strengthen and enforce meaningful differences standards.
- **Risk Adjustment.** ACAP is concerned by CMS' proposal to incorporate preventive services, however, we do support the inclusion of pharmacy data.
- **Rating & Service Area.** ACAP opposes additional Federal requirements that would define rating areas or require issuers' service area to be concurrent with any one rating area, and instead requests that these decisions be left to the states.

- **Medical Loss Ratio.** ACAP supports CMS including fraud prevention costs in the numerator of the MLR calculation, so as not to dis-incentivize issuers from investing in such efforts.
- **Network Adequacy.** ACAP appreciates the need for strong network adequacy standards in order to ensure consumers have access to services without unreasonable delay.
    - **Minimum Threshold for States.** ACAP believes that CMS should not establish Federal time and distance standards, that any network standards should be realistic and attainable, an exception process must be provided, and telemedicine should be included.
    - **Continuity of Care.** ACAP is supportive of the need for continuity of care, but requests that a section be added to indicate that such provisions are only in effect when the provider agrees to accept the previously contracted in-network rate.
    - **Out-of-Network Cost Sharing.** ACAP strongly supports finding a way to decrease the likelihood of enrollees receiving "surprise bills," but recommends that this issue be left to states to address.
    - **Essential Community Providers.** ACAP supports CMS' decision not to further disaggregate the six ECP categories.
    - **Network Breadth Indicator.** ACAP encourages CMS and researchers to continue studying provider networks and contracting trends prior to developing an indicator for HealthCare.Gov.
- **Renewal & Re-enrollment Hierarchy.** ACAP supports the new re-enrollment hierarchy for enrollees in silver-level QHPs that are no longer available for re-enrollment and suggest that issuers be permitted to propose which product is the most similar. Conversely, ACAP strongly opposes CMS' proposed alternative re-enrollment hierarchy.
- **Good Faith Safe Harbor.** ACAP supports the current good faith safe harbor for 2015 but believes it should apply to all components of the 2015 benefit year, including 2015 data *submitted* in 2016. ACAP also suggests that CMS apply the good faith safe harbor standard for two years for all issuers newly entering the Exchanges.
- **Essential Health Benefits.** ACAP supports including medication-assisted treatment for opioid addition to the list of essential health benefits.
- **Navigator Program Standards.** ACAP supports CMS' proposal that Navigators be required to target underserved and/or vulnerable populations within Exchange service areas.
- **Meaningful Differences.** ACAP supports CMS' proposed changes to the meaningful difference standards for QHPs and encourages CMS to enforce meaningful differences law and regulation.
- **Quality Standards.** ACAP supports the goals of patient safety, however, we believe that ensuring standards are met would be best addressed as part of the credentialing process rather than as an annual reporting requirement.

Expanded Comments

ACAP's comments are expanded below, with additional background.

<u>Standardized Plan Options</u>

While ACAP supports CMS' desire to simplify the multitude of plan choices for consumers, so that they are more likely to choose a health plan that best meets their needs, we do not believe that the standardized options as set out in §156.20 are the best approach. While ACAP plans offer a variety of options—some of which are similar to the proposed standardized options, many of which are not—their concerns with the proposed options stem not from the need to redo many of their product offerings (which they would feel obligated to do and which in and of itself would be quite burdensome), but rather from the disruption this would cause in the Exchange—including significant confusion for consumers.

In fact, while ACAP plans have been supportive of standardized plans in principle, such an approach should have been adopted when the Exchanges were established. Creating a set of standardized options four years into the Exchange plan offerings will only create greater confusion and even stifle innovation in plan design. Consumers will likely be discouraged from even looking at other, non-standardized options, which may actually better suit their needs particularly when it comes to cost sharing. For example, some plans currently offered by Safety Net Health Plans have very low or no deductibles at the silver metal level—as opposed to the standardized plans, which have a deductible even at the highest cost-sharing reduction variation.

Likewise, we have significant concerns that the standardized plan designs, as proposed, may not actually be affordable for low-income consumers. Both the bronze and silver metal level options have deductibles and cost-sharing that may be prohibitive for many low income and vulnerable populations. CMS' decision to use coinsurance, so as to better account for regional and other variations in cost, is understandable but may ultimately be misguided—especially where Safety Net Plans often offer products with copayments. High coinsurance, when combined with significantly higher cost-sharing for both primary and specialty care and generic drugs than is generally offered by Safety Net Health Plans, may well price consumers out of being able to actually afford care—even if they have effectuated coverage. It is important not to hinder innovative plan design that may be more affordable for enrollees.

That said, we do support CMS' efforts to standardize and streamline the coverage options available to consumers; the financial and health consequences of inappropriate plan selection can be dire for a consumer. We believe this could be better accomplished, however, by further tightening meaningful difference standards (We recognize and support CMS' efforts to begin tightening meaningful differences standards elsewhere in the regulation). This also would serve to limit the sheer volume of plans available in many FFEs and thus better enable consumers to navigate the variety of offerings: CMS's stated goal for proposing the standardized plan options.

Another such approach worthy of consideration would be to test identifying on HealthCare.gov any plans that also offer a Medicaid product—thus potentially simplifying coverage decisions for low-income consumers that are likely to be churning on-and-off of Medicaid and experiencing disruptions in continuity of care.

ACAP requests that CMS not move ahead with the proposed standardized plan options and instead tighten and enforce meaningful difference standards further.

Risk Adjustment

The risk adjustment model, outlined annually in the Benefit and Payment Parameters, is intended "to mitigate the impact of possible adverse selection."[1] However, ACAP believes that CMS' proposed changes would instead have the opposite effect. For example, while we fully support increased utilization of primary and preventive care (and even support finding ways to reward plans for encouraging such utilization by its enrollees), including preventive services as an HCC simply increases the risk scores of healthier members. This, combined with an overall average decrease in the weights associated with the hierarchical condition categories, does not align with the goals of risk adjustment: to protect against unexpectedly high risk.

ACAP is concerned that the proposed changes to the risk adjustment model degrade its protection of health plans serving high-risk, high-need populations.

ACAP is, however, supportive of CMS' proposal to include pharmacy data in the risk adjustment model. Issuers often use pharmaceutical data as their first line of knowledge about enrollees who have not yet initiated care, and as such recognize the value that could be tapped by CMS' use of pharmaceutical data in the risk adjustment model. Such data will enable CMS to paint a more accurate picture of each plan's enrollees and their respective risk scores. However, in the case of using pharmacy data in addition to diagnosis codes, we urge CMS to consider how best to address the fact that one drug may be used to treat multiple conditions—both on and off-label—and thus could be mapped to multiple HCCs. Accordingly, we encourage CMS to provide a proposed mapping of drugs to HCCs for issuer feedback.

ACAP is supportive of including pharmacy data in the risk adjustment model but we urge CMS to study how best to address the fact that drugs can be used to treat multiple conditions, thus impacting the mapping of drugs to HCCs.

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[1] Department of Health and Human Services. "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014 and Amendments to the HHS Notice of Benefit and Payment Parameters for 2014; Finals Rules; Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program; Proposed Rule." March 2013. Page 15412.

Rating and Service Area

CMS is contemplating placing additional requirements on how states define rating areas with the ultimate goal that rating areas would be more uniform nationwide. In addition, CMS is seeking comments on aligning an issuer's service area with its rating area.

Rating areas are unique to each state, based on local market conditions, and should remain that way. We do not believe that CMS should mandate that rating areas have certain features, as it is difficult to create a nationwide standard that can apply both to large states with high variances in population density, like Texas, and small, homogenous states, such as Rhode Island. State regulators with knowledge of their market are best equipped to make these determinations. In addition, new rating area standards, which would require states to alter currently set rating areas, could destabilize market rates and lead to consumers seeing significant changes in rates from one year to the next.

ACAP also opposes requiring that an issuer's service area cover an entire rating area. Some Safety Net Health Plans participating in the Exchange are only doing so in a subset of a rating area; this change would require them to potentially expand their service area in order to continue participating in the Exchange. The decision to participate in a smaller service area may be based on the amount of financial risk that particular issuer is able to take, in order to ensure a robust provider network, or in order to maintain continuity with the service areas they participate in for the Medicaid program. For these reasons, aligning rating areas and service areas may actually serve as a deterrent to Safety Net Health Plans entering or remaining in the market in the future. Furthermore, if combined with a standardized definition of rating areas, the impact on plans would be greatly exacerbated.

ACAP requests that CMS allow states to continue to define rating areas and not require issuers' service areas correspond with entire rating areas, as such changes would have an unduly negative impact on Safety Net Health Plans.

Medical Loss Ratio (MLR)

Excluding fraud prevention activities from the numerator of CMS's MLR calculation, as is the case currently, seriously understates the value of proactive fraud and abuse avoidance efforts. In fact, excluding such activities may well dis-incentivize issuers from making such efforts because they would effectively increase administrative costs, therefore decreasing a plans' MLR. Aiming to ensure that everyone gets the most out of the health care system by focusing on decreasing wasteful spending and avoiding potentially harmful activities, such as unnecessary or duplicative services, has a direct relationship to improving health outcomes and should be counted as incurred claims. Moreover, the limitation of fraud and abuse expenses to amounts recovered for the purposes of calculating MLR is detrimental to the continuation of cost-effective, cost avoidance activities. As such, we are pleased to see that CMS is rethinking its approach on this. Alternatively, expenses attributed to waste, fraud, and abuse could simply be excluded from the MLR calculation altogether.

ACAP is in favor of CMS including expenses associated with fraud, waste, and abuse avoidance activities in the numerator of the MLR calculation.

Network Adequacy

As the primary mode for ensuring consumers have access to services without unreasonable delay, we understand the need for strong network adequacy standards. We seek to provide feedback on numerous components of the network adequacy standards laid out in the draft Notice.

Minimum Threshold for States- §156.230(d)

CMS is proposing that FFE states pick one or more standards from a list of proposed metrics and also review and approve issuers' provider networks against those standards. Similar to Medicare, CMS also intends to release default time and distance standards for FFE states that do not select an appropriate standard for network adequacy, however, we are concerned about CMS' choice of time and distance standards at the county level.

Although ACAP strongly believes in the importance of ensuring consumers have access to care, we oppose CMS setting benchmark time and distance standards since states can best address local conditions. We appreciate that CMS' proposal would first have states set their own standards; however, we are concerned that in an effort to address anxiety related to access, CMS is acting too hastily in considering a uniform standard. We believe that CMS ought to allow states to examine their local markets and set appropriate standards—especially since many are already in the midst of doing exactly this. States may also want to align their Medicaid Managed Care quantitative standards with their Exchange standards and CMS' benchmark might impede a state's ability to do so. In addition, specifying the types of quantitative standards for states also may not be appropriate. For example, as noted by the National Academy for State Health Policy (NASHP), "at least one state recently stopped using timeliness in its urban areas as a measure of access and now only uses distance due to the high volume of traffic, which can be unpredictable."[2] CMS benchmarks would not afford states this type of flexibility, stifling innovation in developing more meaningful standards to measure consumers' access.

While ACAP is not opposed to CMS requiring that states develop quantitative standards, we do not believe CMS should develop a benchmark time and distance standard or a specified list of quantitative standards a state must choose from.

Furthermore, whether it's CMS or a state setting network adequacy quantitative standards, it is important that network adequacy standards are realistic and obtainable. Any network adequacy standards should reflect local conditions as they exist today and not as CMS or the state would like them to be. Therefore, we appreciate the recognition of the need for variation in the standards for different geographic locations and the need for an exception process. We also believe it is

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[2] "Managed Care Notice of Proposed Rulemaking." National Academy for State Health Policy. 16 July 2015. http://nashp.org/managed-care-notice-of-proposed-rulemaking

important that network standards recognize the concept of value-based networks and the emerging use of technology to deliver care.

Increasingly, telemedicine is becoming a viable alternative for making a health plan provider networks more robust. However, there is no recognition in many states or in the proposed regulations of this value. We ask that CMS require states to recognize telemedicine in assessing the health plan's performance against the network adequacy standards where a plan can demonstrate that telemedicine is a viable alternative to increase access and improve care and is not contrary to state law.

Network Adequacy standards must be realistic and attainable, an exception process must be provided, and telemedicine should be included as a mechanism for meeting access standards.

<u>Continuity of Care- §156.230(e)</u>

ACAP plans understand and are supportive of the need to provide members with continuity of care upon a provider termination. As per the draft Notice, carriers will be required to allow a member in active treatment with a provider whose contract has been terminated without cause to continue treatment for up to 90 days or until the treatment is complete, whichever is less. However, the regulation, as drafted, does not provide adequate protection for issuers. We believe that a section should be added to §156.230(e) to clearly indicate that the continuity of care provisions are only in effect when a provider agrees to accept the previously contracted in-network rate. This suggested specification is consistent with the language in the NAIC Network Adequacy Model Act. If this requirement is not added, providers in states without such a protection would be able to select a price for services rendered under the continuity of care provisions and issuers would be required to accept it in order to meet these regulatory requirements. This could change the market dynamics between providers and issuers and ultimately lead to premium rate increases.

ACAP supports CMS' proposed continuity of care provisions on the condition that it is specified that these provisions are only in effect when a provider agrees to accept the previously contracted in-network rate.

CMS also asked for feedback regarding extending active treatment for pregnant women through the post-partum period. ACAP is supportive of this extension, assuming the above criterion on in-network rates applies.

ACAP supports extending the definition of active treatment for pregnant women through post-partum services.

<u>Out-Of-Network Cost Sharing- §156.230(f)</u>

To address the costs associated with enrollees unknowingly receiving out-of-network care for essential health benefits, CMS has proposed that both FFE and SBE issuers must count services rendered by an out-of-network provider at an in-network setting towards members' annual cost sharing limitation, unless the issuer notifies a member 10 days prior to the procedure about the

potential to be seen by an out-of-network provider. ACAP strongly supports finding a way to decrease the likelihood of members receiving "surprise bills," but we also recognize that many states are currently working through this issue and should be allowed to do so. Many states are thinking about approaches to address balance billing situations, including the adoption of the recently released NAIC Network Adequacy Model Act, and may be able to do so in a more effective manner—particularly given that the proposed requirements do not actually prevent such surprise bills and the enrollee would remain liable for a large portion of them. Additional federal requirements may be in conflict with or pose challenges to state solutions already underway.

ACAP believes issues related to balance billing should be left up to the states and therefore opposes CMS's proposed out-of-network cost sharing requirements in §156.230(f).

<u>Essential Community Providers (ECP)- §156.235</u>

Currently FFE issuers are expected to contract with at least one ECP in each of the six CMS designated ECP categories. CMS contemplated disaggregating some of the categories but ultimately decided not to because it would not "afford issuers sufficient flexibility in their contracting" (page 75552). ACAP is supportive of this decision.

ACAP supports CMS' decision not to further disaggregate the ECP categories.

<u>Network Breadth Indicator for HealthCare.Gov</u>

ACAP very much supports CMS' efforts to improve transparency in plan choices and improve the consumer decision-making process. We understand the drastic impact narrow versus broad networks can have, and hence why CMS is considering adding an indicator on HealthCare.Gov to aide consumers in understanding the breadth of an issuer's network. However, there is currently no universally recognized definition for various network sizes and a narrow network may mean something very different in one state versus another, or even from one region within a state to another (rural versus urban, etc.) and we believe this would need to be addressed first.

ACAP encourages CMS and researchers to continue studying networks and provider contracting trends prior to developing a network breadth indicator for HealthCare.Gov.

<u>Re-enrollment Hierarchies</u>

ACAP supports CMS' efforts to minimize potential enrollment disruptions for individuals enrolled in QHPs. We support the new re-enrollment hierarchy for enrollees in silver-level QHPs no longer available for re-enrollment, as specified at §155.335(j), which would place enrollees in the QHP product most similar to the enrollee's current product, rather than one metal level higher or lower. CMS requested comment as to how best to determine which product is most similar to the enrollee's current product. We suggest that QHP issuers be permitted to decide which plans are most similar, since they will be most familiar with the variations in their products, and pose it to CMS as part of the QHP template submission process.

ACAP supports the proposed re-enrollment hierarchy for enrollees in silver-level QHPs and urges CMS to permit the QHP issuer to determine the most similar product.

However, we strongly discourage CMS from taking up the alternative re-enrollment hierarchy also described in the Notice. While we support efforts to ensure affordable coverage, we do not support passive enrollment into an alternative product determined on the sole basis of premiums. We fear that such a process would result in both confusion and discontent among consumers. Other factors besides premiums factor into both decision making and satisfaction, including provider networks, pharmaceutical formulary, and additional cost factors such as copayments and out-of-pocket maximums. Such an approach would furthermore disrupt any continuity of care and care management strategies put in place by the issuer, thereby potentially having a negative impact on enrollees' health. Furthermore, an issuer's risk pool could be significantly impacted if, for example, premiums increase due to an extremely strong provider network but individuals who have enrolled solely based on premiums are automatically removed from the plan; in such a scenario it is conceivable, if not likely, that a small issuer's very solvency would be threatened. Finally, any effort QHP issuers have made to develop and employ retention strategies would be rendered useless.

Should CMS move forward with such a process, it is imperative that the potential for disruption in care, provider networks, and pharmaceutical formularies be made clear to enrollees, as well as the potential for other differences in cost-sharing and potential out-of-pocket expenses. It would be vital that CMS also permit any such enrollees re-enrolled into a different QHP product be permitted a special enrollment period allowing them to opt back into their previous coverage, should they choose.

ACAP strongly discourages CMS from implementing the alternative re-enrollment hierarchy described in the draft Notice, given the high potential for negative consequences to the enrollee. Should CMS move forward with any such process, the potential impact of such changes must be made explicit to enrollees, who ought to be permitted a special enrollment period if they wish to return to their previous coverage.

Good Faith Safe Harbor

As we stated in our comments on the 2016 Notice of Benefit and Payment Parameters, ACAP supports the current good faith safe harbor standard as it relates to the risk adjustment, reinsurance, and risk corridor programs under §153.740(a). While we did not expect the good faith safe harbor to be extended the 2016 benefit year, we do want to reiterate that we disagree with CMS' approach of not applying the good faith safe harbor to apply to 2015 data *submitted* in 2016. It only makes sense for the safe harbor to apply to all components of the 2015 benefit year, regardless of whether the data is submitted in 2015 or 2016.

Furthermore, given the fact that the Exchanges are so new—in particular for many Safety Net Health Plans, which have never participated in the commercial markets—we encourage CMS to apply the good faith safe harbor for the first two years for all issuers newly entering the Exchanges. We expect at least two Safety Net Health Plans to newly offer coverage in the

Exchanges in 2017 and under current rules they would be unduly subject to civil monetary penalties that other issuers will have had two years to prepare against.

ACAP supports extending the good faith safe harbor standard to include all 2015 benefit year data reported in 2016. ACAP also suggests that CMS apply the good faith safe harbor standard for two years for all issuers newly entering the Exchanges.

Essential Health Benefits

CMS is contemplating making medication-assisted treatment (MAT), a treatment option for opioid addiction, an essential health benefit. Whether in their Medicaid, Exchange, or Medicare line of business ACAP plans are cognizant of the opioid addiction epidemic and are investing in efforts to address opioid abuse.[3] We are supportive of CMS adding MAT to the essential health benefits.

ACAP supports adding medication-assisted treatment to the list of essential health benefits.

Navigator Program Standards

As part of an expanded role for Navigators, including post-enrollment and other assistance activities, CMS proposes that Navigators target underserved and/or vulnerable populations within the Exchange service area, with the specific populations to be identified by each Exchange. Given Safety Net Health Plans' historical participation in Medicaid, they are uniquely focused on and versed in providing coverage to underserved and vulnerable populations. Many Safety Net Health Plans have, in fact, opted to offer coverage in the Exchanges in order to reach the large segment of the Medicaid population that would otherwise be churning on-and-off of coverage. Accordingly, ACAP applauds CMS' focus on targeting underserved and vulnerable populations in the Exchanges at §155.210(e)(8). We recognize the difficulty of defining underserved and vulnerable populations writ large, but agree with the approach to generally identify these populations as those that are disproportionately without access to coverage or care or are at greater risk for poor health outcomes.

ACAP supports CMS' proposal that Navigators would be required to target underserved and/or vulnerable populations within Exchange service areas.

Meaningful Differences

As mentioned previously, we are supportive of CMS' proposed tightening of meaningful differences standards at §156.298. Current rules require QHP issuers to vary all plans in the same metal tier and plan type to ensure that consumers can easily understand differences between

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[3] "Strategies to Reduce Prescription Drug Abuse: Lessons Learned from the ACAP SUD Collaborative." Association of Community Affiliated Plans. April 2015.
http://www.communityplans.net/portals/0/fact%20sheets/ACAP_Substance_Use_Disorder_Toolkit.pdf

available options. We encourage CMS to both further tighten and enforce meaningful difference standards as set out in regulation.

ACAP supports CMS' proposed changes to the meaningful difference standards for QHPs and encourages CMS to enforce meaningful differences law and regulation.

Quality Standards

We appreciate CMS' efforts to ensure strong patient safety standards for enrollees of QHPs. While we support patient-centered quality improvement efforts such as those laid out in the draft Notice, we are concerned about both the potential need for issuers to renegotiate all of their contracts in order to add language requiring hospitals with greater than 50 beds use of a patient safety evaluation system and comprehensive person-centered discharge program to improve care coordination and health care quality. We are further concerned about the burden issuers would necessarily undertake in order to truly verify that such hospitals are actually in compliance with the established standards—rather than just partnering with a Patient Safety Organization, for example. We suggest, instead, if CMS retains the proposal at §156.1110, that issuers be required to verify compliance at the time of credentialing rather than on an annual basis.

ACAP is concerned about the burdensome nature of verifying and ensuring compliance with the new quality standards and request CMS make the requirements apply at the time of credentialing rather than on an annual basis.

Conclusion

ACAP thanks you for your willingness to discuss these issues with us. If you have any additional questions or comments, please do not hesitate to contact Heather Foster (202-204-7518, Hfoster@communityplans.net).

Sincerely,

Margaret A. Murray
Chief Executive Officer