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Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
**Attention: CMS-9989-P**  
P.O. Box 8010  
Baltimore, MD 21244-8010

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

The Florida Association of Community Health Centers, Inc. (FACHC) is pleased to respond to the above-cited request for comments from the Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) regarding the codification of the rule relating to the Health Information Exchange (HIE) proposed through the Patient Protection and Affordable Care Act (PPACA, or ACA).

FACHC is the Florida primary care association (PCA), representing the state's 45 federally qualified health centers (hereinafter interchangeably referred to as FQHCs, CHCs or Centers) and over one million Florida residents (patients). Our organization is a private and non-profit, whose goal is to advance the quality and effectiveness of the most cost-effective form of providing primary care in the State.

FACHC is focusing our comments primarily on proposed rule provisions of the Affordable Care Act's Health Insurance Exchange (ACO) that have direct influence on our members, as well as any proposed regulations that may have an impact on our organization, as a small business. In general, FACHC has found the rule to be thoroughly considerate and well constructed; but we appreciate the opportunity afforded to us by CMS to suggest improvements and/or discuss any concerns we have with specific pieces of the rule.

Regards,

A handwritten signature in black ink, appearing to read "Andrew Behrman", with a long horizontal flourish extending to the right.

Andrew Behrman  
President and CEO  
Florida Association of Community Health Centers

## I. Background

At present, there are approximately 45 Federally Qualified Health Centers (henceforth referred to as FQHCs, CHCs or Centers) with more than 300 service locations, employing nearly 6,000 FTEs who provided care to more than 1 million patients<sup>1</sup> during nearly 4 million encounters across Florida<sup>2</sup>. A majority of these FQHCs receive federal grants under Section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) from the Bureau of Primary Health Care (BPHC), within the Health Resources and Services Administration (HRSA) of HHS.

Under this authority, health centers generally fall into four care-provision categories, though a number of them qualify for more than one category of funding – and ALL of them see every single patient that walks through their door or seeks healthcare services. The centers can be categorized by patient base as:

- (1) Medically underserved areas
- (2) Homeless populations within a particular community or geographic area
- (3) Migrant/Seasonal Farmworker populations within similar community or geographic areas, and/or
- (4) Residents of public housing

Only one Floridian FQHC does not receive a Section 330 PHS Act grant. However, this CHCs has been determined by CMS (per recommendation of HRSA) to meet all the requirements that must be met by Section 330 grantees (Sections 1861(aa)(4)(B) and 1905(l)(2)(B)(iii) of the Social Security Act). This FQHC is often referred to as “FQHC look-alikes.”

To qualify as a Section 330 grantee, a health center must:

- (1) be located in a designated medically underserved area (MUA) or serve a medically underserved population (MUP)
- (2) a health center’s board of directors must be made up of at least fifty-one percent (51%) users of the health center
- (3) must offer services to all persons in its area, regardless of one’s ability to pay<sup>3</sup>

In Florida, 33.7 percent of health center patients are Medicaid recipients, 49.0 percent are uninsured and approximately 6.2 percent are Medicare beneficiaries. The uninsured patient population of FQHCs of 33.7 translates into more than 507,000 individuals receiving services from Florida’s FQHCs that are not accompanied by either private or government forms of insurance. The proposed rule intends to amend these data in such a way that FQHCs may potentially benefit and become more financially solvent.

Of those for whom their income information is known (82.9% of FL FQHC patients), 69.8 percent are at or below 100 percent of poverty – but this increases to 88.1 percent (720,000) when including those at or below 200 percent of poverty. This reality contributes to the high rate of uninsured patients seen at Florida’s FQHCs, as those in extreme poverty cannot afford coverage and may not be knowledgeable – or may not qualify – for government-backed insurance programs.

The simple fact that these centers can provide these services for the lowest price in the state – at this level of uncompensated care – and end each year (statewide) with an operating margin in the black is nothing short of a miraculous testimony to the value and fortitude of the FQHCs in one of the most populous states in the country. However, it is hoped that the rule’s outcome will produce more individuals who have coverage and a greater capacity to seek care, increasing health, saving costs in the long run and making an investment in their personal health outcomes.

### **Congressional Recognition of the Value of FQHCs and its Intent to Expand FQHC Services**

Congress has consistently and frequently recognized and supported the role of health centers in providing critical primary care services in medically underserved communities throughout the country. It has done so by repeatedly passing legislation that has enabled health centers to expand and increase their services. Examples of this consideration include discounted drugs to FQHCs through the Section 340B program, Federal Tort Claims Act coverage for FQHCs and their employees and Social Security Act (SSA) provisions that require fair and adequate reimbursement to FQHCs to cover their costs in treating Medicaid and Medicare (and, recently, CHIP) patients.<sup>4</sup>

## II. CMS’ Proposed HIE Rule Regarding FQHC Reimbursements

The Centers for Medicare and Medicaid Services has laid out in their proposed rule a suggestion for two options regarding FQHC

<sup>1</sup> Providing comprehensive health care services for about 1/18<sup>th</sup> of the 4<sup>th</sup> largest state’s entire population

<sup>2</sup> Data compiled by FACHC through receipt of each FQHC member’s audited 2010 UDS report

<sup>3</sup> BPHC’s grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing comprehensive preventive and primary care and enabling services (e.g. translation, transportation services, disease management)

<sup>4</sup> Sections 340B and 233(g)-(n) of the PHS Act and Sections 1902(bb) and 1833(a)(3) of the Social Security Act

required/voluntary inclusion within (and payments by) qualified health plans (QHPs)<sup>5</sup>:

1. Require QHP issuers to pay at least the Medicaid PPS rate to each FQHC that participates in the issuer's QHP network
2. Permit 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

Whereas FACHC applauds the attempts of CMS to reconcile the requirements in the Patient Protection and Affordable Care Act<sup>6</sup> (henceforth referred to as ACA) to the benefit of the FQHC fiscal sustainability and inclusion, FACHC would also like to express concern for potential pitfalls that may result from these proposals doing harm to individual Centers' fiscal viability and participation in expanding access to underinsured and underserved populations in Florida and around the country. For example, neither suggested option specifies that FQHCs be included as essential providers, of which QHPs must include FQHCs.

**The option of QHPs to NOT include essential providers should, unquestionably, be removed– as FQHCs are often the *only* source for care in predominately low-income, medically-underserved rural and urban centers.**

Though this aspect appears integral to the two CMS proposals, it all but guarantees FQHCs not be included within the QHPs, unless the Centers were to acquiesce to the proclivities of the QHP – be they beneficial or detrimental to the Center's viability and access to care for vulnerable citizens. In either proposed option, the FQHC would appear to be at a disadvantage. As FQHCs are often the only provider other than hospital emergency rooms, the choice to allow QHPs to exclude FQHCs would essentially revoke affordable medical care from millions of Americans.

### **Proposed Rule May Reduce Access for Many of America's Neediest Patients**

Depending upon the outcome of the rule and the determination of payment requirements and essential provider inclusiveness, FQHCs may be able to expand upon one of the best health care programs in existence or they may be forced to shut their doors and force millions of Americans to go without health care until it is too late.

Rather than citing excessive numbers of studies that prove that FQHCs are successful providers of high quality, coordinated cost-effective primary and preventive care, FACHC has included below<sup>7</sup> a number of studies and reports that support this premise. CMS has even stated that it concurs with such, by stating:

*"FQHCs and RHCs have long delivered comprehensive, high-quality primary health care to patients regardless of their ability to pay, and increase access to health care through innovative models of community-based, comprehensive primary health care that focus on outreach, disease prevention, and patient education activities. FQHCs provide high-quality care to rural and urban populations alike by focusing attention on improving public health through preventive care in addition to direct patient care. Not only do health centers provide critical, high quality primary care in the Nation's neediest areas, but reports have shown that the health center model of care can reduce the use of costlier providers of care, such as emergency departments and hospitals... For example, regarding FQHCs, data show health center Medicaid patients were 11 percent less likely to be inappropriately hospitalized and 19 percent less likely to visit the emergency room inappropriately than Medicaid beneficiaries who had another provider as their usual source of care."<sup>8</sup>*

It seems reasonable to assume that the insured beneficiary growth rate at centers will continue to increase in the upcoming years since the ACA has laid out a plan substantial health center and coverage expansion. Although data from the Bureau of Primary Health Care's Health Resources and Services Administration's 2010 Uniform Data Systems (UDS)<sup>9</sup> indicate that 2.7 million privately insured and 500,000 publicly insured patients crossed the thresholds of FQHCs nationwide in 2010, a majority of patients being treated at FQHCs continue to be an at-risk population (both financially and in terms of health). This can be partially

<sup>5</sup> II. Provisions of the Proposed Regulation

B. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

2. Subpart C—Qualified Health Plan Minimum Certification Standards

f. Essential Community Providers (§ 156.235)

<sup>6</sup> Section 1311(c)(2) and Section 1302(g), as amended in Section 10104

<sup>7</sup> A list of studies and reports can be found at:

<http://www.nachc.com/client/documents/HC%20Quality%20Studies%2004.11.pdf>

<http://www.nachc.com/client/documents/HC%20Cost%20Effectiveness%20Studies%2002.11.pdf>

<http://www.nachc.com/client/documents/HC%20Disparities%20Studies%2004.112.pdf>

<http://www.nachc.com/client/documents/HC%20access%20to%20care%20studies%2004.11.pdf>

<sup>8</sup> Preamble to CMS Proposed ACO Rule; CMS-1345-P

<sup>9</sup> <http://bphc.hrsa.gov/healthcenterdatastatistics/index.html>

attributed to the fact that health centers are located in medically underserved areas, which often are low-income areas<sup>10</sup> and patients have had difficulty accessing care.

FQHCs served more than 7.5 million Medicaid and almost 1.5 million Medicare beneficiaries nationwide. Currently, these populations are being treated by FQHCs at a growing rate, due to various socioeconomic and geographic realities with which these individuals were not previously confronted – as well as the successes achieved as a result of increased funding through the ACA that has allowed for significant site and services expansions. Many would consider these populations to be among the most vulnerable, as qualifying for these benefits often is accompanied by poverty and a lack of resources (e.g. adequate transportation). To increase barriers to care for these individuals begins to border on irresponsible and should be avoided to whatever extent is possible.

Similarly, FQHCs have become a medical home to over 7.3 million uninsured Americans. Though this identifying characteristic may – hopefully – be one of the past within the next three years, it does not alleviate the fact that these individuals are among those most in need of critical health services. This group of citizens is often not as readily able to acquire proper nourishment, health education and/or timely treatment. The result of this is that they often end up utilizing the overcrowded and expensive hospital emergency rooms – at the expense of the insured and the government payers. FQHCs have served – and plan to continue serving – as the pre-emptive medical interventionary, wherein they reach out into communities and work with those that are in this situation (un/underinsuredness, poverty, misinformed/uninformed, etc) and bring them into the health care system prior to the exacerbation of chronic and/or other serious health ailments, concerns and conditions. By so doing, FQHCs are hedging back the tide of increased costs to the system and encouraging healthy behaviors in millions that may not otherwise be provided this opportunity.

The proposed rule stresses the importance of bringing “essential providers” into their systems and maintaining a viable system of access in all geographies – regardless of the final determination of plan provision and geographical outlays<sup>11</sup>. This concern and admonition only strengthens our initial point, that these proposed regulations have a disconcerting potential of reducing or denying access to care for nearly 19.5 million Americans; mostly high risk patients – who are increasingly being treated by FQHCs.

**This proposed rule(s) undercut the agency’s attempt to assure at risk patients are brought into the HIE system.**

### **Flexibility in Participants & Payment Structure**

This subsection [II(B)(2)(f)] of the HIE proposed rule suggests that CMS has been afforded the leeway and opportunity to develop implementing options for, or adjustments to, payment and inclusion models other than those specifically outlined within the ACA. Specifically, this subsection speaks to a desire for comment on potential interpretations of the written law through the rule, as those choice options were not as the original letter of the ACA designed.

CMS clearly alludes to the fact that it is compelled by the necessity within the provisions of Section 1311(c)(2) and Section 1302(g), as amended, of the ACA to find a compromise within the expanse of Title I of the ACA in relation to FQHC inclusion/exclusion within QHP and fiscal structures.

Section 1311(c)(2) states:

*Nothing in paragraph (1)(C)<sup>12</sup> 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.*

On the other hand, Section 1302(g), as amended, states:

*PAYMENTS TO FEDERALLY-QUALIFIED HEALTH CENTERS – If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment [PPS rate] that would have been paid to the center under section 1902(bb) of such Act (42 U.S.C. 1396a(bb)) for such item or service.*

<sup>10</sup> For example, more than 55 percent of all FQHC patients in 2010 were at or below 100% of the federal poverty level (FPL). This excludes any patients that fall within the category of “unknown” income level (or over 13% of the patient population).

<sup>11</sup> E.g.: II. Provisions of the Proposed Regulation

2. Subpart B—General Standards Related to the Establishment of an Exchange by a State

<sup>12</sup> Section 1311 (c)(2)(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 and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111–8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;

CMS seeks to find a common ground, or best fit of the interpretations of the law, to arrive at a resolution to the FQHC essential provider and PPS issues. FACHC proposes herein to provide that answer, which has a likelihood of finding the greatest consensus amongst stakeholders.

It is with this presumed flexibility and ardor for compromise that FACHC recommends the implementation of the following outlined option, which utilizes the best aspects of the scenarios described by both CMS and following the FACHC recommendation.

### **FACHC Recommendation**

FACHC recommends strongly that the Medicare rate should be the starting point for negotiations between FQHCs and QHPs – which are required to include FQHCs as essential providers in their plans. Using a selective combination of various elements of the following scenarios, FACHC finds that it would be best for patients, CHCs and QHPs if the Centers were able to stay open, flourish and provide quality, reasonably priced healthcare services to all patients (especially, as is most often the case for FQHCs, those that are underserved and/or underinsured) across the country.

The conundrum of being required to purchase healthcare coverage will likely not solve the perplexing issue of making sure everyone receives care in a timely and cost-efficient manner – as some will opt for plans that fall well below the designation of “Cadillac” and many will continue to opt not to get coverage (as some will find the penalty either ineffectual to their overall personal budget or inconsequential to their day-to-day life).

However, should CHCs be provided the opportunity to negotiate rates on an individual Center-by-Center basis, they may be able to best weigh their community’s priorities and needs with payment options to find the highest common ground between charging and collecting in the light of using the Medicare rate as the basis for negotiating the reimbursement for services upwards and downwards. As QHPs will be required to offer minimum coverage options, FQHCs will be able to assist them in better understanding the expected losses and balancing of services on a local, geographically determinate area.

With these two entities working together, in collaboration with others in the area (e.g. hospitals), the best fiscal outcomes and patient service access should be able to be achieved. The FACHC Hybrid Model will provide an inclusion and expansion of services that is critical to not only maintain current levels of care, but also account for the foreseeable increases of insured individuals that are to be forthcoming upon the implementation of the coverage penalties, as well as the incentives.

### **Discussion of Alternate Options**

#### **CMS Scenario One: Medicaid PPS Only**

By paying the full PPS rate to a Center for services rendered, the CMS rule would then allow for multiple beneficial results:

- (1) The current financial planning and financial billing policies and software of FQHCs can remain in place regarding the Medicaid/Medicare patient base which will reduce the need for costly replacement or recoding of costly billing software and retraining of financial staff
- (2) The current strategic planning policies of FQHCs can remain in place
- (3) The QHP would be guaranteed payment consistency and assured of a level of cost predictability

Each Center currently is aware of populations in their geographic areas that are in greatest need of service and, by keeping the PPS rate and requiring inclusion in QHPs, FQHCs will be able to continue their focus on these populations, allow for these individuals to remain within their current medical homes and avoid interruptions of service for vulnerable populations that can ill afford such interruptions.

As opposed to other providers, who may negotiate (or be offered) a buffet of reimbursement rates that are completely dependent on patient independence/risks, FQHCs would provide to QHPs budget predictability. By having a single payment amount, a consistent, long-term trend of data can be utilized (in the case of FQHCs, through the use of UDS reports) to develop a strong, reliable business strategy.

Though this option appears to be more financially palatable to Centers than the alternate option, it may result in the exclusion from QHPs. As noted within the proposed rule, the theory behind this logic is that, should QHPs be allowed to pay other providers a lower amount, then they will choose to exclude FQHCs to ensure lower costs to their business model. Were this to be the case, then a significant patient base would be encouraged to receive care from healthcare sources other than FQHC locations and many Americans would lose out on an opportunity to receive convenient, critical services.

Additionally, if the provision to require FQHC/essential provider inclusion was incorporated into the rule, then a “known-known” would enable states, QHPs, FQHCs and – most importantly – patients have reliable forecasting and

#### **CMS Scenario Two: Negotiation of Rates**

This option would appear to be the most logical direction, considering the current healthcare environment and that of the potential future. Considering the opening of the marketplace to more Americans and the potential flood of millions into the environment, the QHPs will be looking for the best opportunities to maximize profits, while ensuring sustainable and services-inclusive plan options. By enabling a negotiation process, the QHP is able to balance its non-FQHC provider fiscal requirements and pricing structure(s) with those of the FQHCs.

The benefits to this option are also many:

- (4) FQHCs will be provided with the option of receiving a greater reimbursement for a number of services for which they are currently unable to cover 100% of costs
- (5) QHPs will be able to expand their service areas and include a greater potential patient base
- (6) QHPs will be able to streamline their accounting/financial systems to a standardized pricing buffet

The advantages seem to favor QHPs, though this may be at the expense of the patients. However, though the benefits may potentially expand the patient-base for QHPs and offer more individuals coverage (which can reduce the number of Americans incurring the non-coverage penalty), it may be at the expense of FQHCs and, therefore, reasonable and reliable service options. A significant portion of FQHC encounters are for symptoms that qualify as non-emergent, which would likely be paid out at a rate lower than the PPS rate they currently receive for all services – regardless of severity. With lower reimbursements, fewer costs will be covered, which may result in a reduction of staff, a reduction of locations and/or a reduction of services being offered.

#### **FACHC Scenario One: PPS Minimum**

One proposed option is to pay FQHCs a *minimum* of the PPS rate. Through this option, FQHCs would be required to negotiate rates for services *only* above and beyond the cost of the PPS rate. For example, if an annual physical exam costs less than PPS, then the QHP would be required to pay the FQHC at their PPS rate. However, should the cost of a procedure, such as the delivery of a baby, exceed the PPS rate, the QHP would be given more leverage in controlling the ceiling of their own costs by being able to negotiate openly with individual FQHCs – which may result in a lower cost for a given service than if it was provided elsewhere. The theory behind this result is that, if FQHCs are granted *at least* their PPS rate for all services, then they are more likely to agree on negotiating downward those procedures that are more costly, since they are able to compensate for any losses through the PPS rate for less expensive services (which are more common at FQHCs).

In this option, the requirement for FQHC inclusion in QHPs should remain as something that cannot be circumvented.

#### **FACHC Scenario Two: PPS Maximum**

A second proposed option is to pay FQHCs a *maximum* of the PPS rate. Obviously FQHCs will not be as enamored with this choice, as it opens the door to the potential of losing significant revenues, which are desperately relied upon to remain in business. At present, with nearly 50% of Florida's FQHC patients (38% nationally) being uninsured, the FQHCs throughout the state rely heavily upon being paid a [PPS] rate that, with wrap-around, is able to cover a significant portion of the costs of patients' visits. However, should this rate be reduced through negotiations (in a desire to retain patients), FQHCs will become susceptible to bankruptcy.

In this option, the requirement for FQHC inclusion in QHPs should remain as something that cannot be circumvented.

As of the 2009 Tax Year, Florida's FQHCs have made significant strides over the previous five years, fiscally. What was once a recurrence of Centers fraught with ending their fiscal years (FYs) in the red has dramatically reversed itself and now boasts a healthier system, in which a vast majority of centers are able to finish in the black – no matter the extent to which this may be true.

This option is not presented as a recommendation, but, rather, as a warning – perhaps even an extreme one. If CMS desires the implosion of one of the most cost-efficient, reliable and widespread ties in the healthcare safety net, then making FQHCs vulnerable to being underpaid is an astute way of achieving this goal. However, FACHC believes this to not be the case and encourages CMS to avoid language that may be written into the final ruling that would even remotely resemble this trail of logic. Though QHPs may prefer such an option – or a variation thereof – it would be unwise to put at risk the Centers that may be the only location to receive health services within a hundred miles (as is the case in dozens of rural communities throughout the country).

#### **FACHC Scenario Three: Medicare Rate**

An option not discussed thus far is to allow FQHCs to begin negotiations – or established minimums/maximum at the Medicare rate. As per the ACA<sup>13</sup>, 2014 will bring with it increased Medicaid rates that are meant to mirror those of Medicare, but this provision (As with all provisions of this law) is not guaranteed to still be in place by 2014. In light of this, it may be desired by FQHCs and/or QHPs to pre-empt the inevitability of the implementation of this provision or to ensure participation in the QHPs by

<sup>13</sup> Section 2001(a)(3)(B)

as many providers as is feasible/possible – which would result in greater enrollees for the QHPs.

In this option, the requirement for FQHC inclusion in QHPs should remain as something that cannot be circumvented.

Although this option may be seen as a grand compromise – as it enables QHPs to have the budget stability and increased enrollments, while FQHCs are provided increased patient bases and a more generous funding source – it may be a non-starter for some involved in the negotiations (should negotiations follow the example(s) as provided in FACHC options 1 & 2).

### **III.CMS' Proposed HIE Rule Regarding Small Business Health Options Programs (SHOPs)**

The outcome of this proposed rule will impact millions of Americans and thousands of small business nationwide. FACHC is one example of a small business that offers health insurance to employees and will be directly impacted by and feel the repercussions of the decisions made by the final publication of this rule.

We applaud the Centers for Medicare and Medicaid Services' proposed rule regarding the Small Business Health Options Program [SHOP] in Part II, Section A(5)(Subpart H). CMS' recommendations amount to an intuitive plan for the implementation of the SHOP. Throughout the text of the proposed rule, CMS makes numerous suggestions and requests for comment regarding a wide variety of specificities within their outline.

The following section of this submission provides FACHC's suggested input and insights into the development of SHOPs.

#### **5. Subpart H—Exchange Functions: Small Business Health Options Program (SHOP)**

As alluded to previously, FACHC is in agreement with a significant portion of this Subpart of the proposed rule. For example, the suggestion that participation in a SHOP is strictly voluntary for small employers speaks not only to the freedom of choice granted to individual business environments, but also promotes an opportunity to enter into the system when the SHOP best fits with an individual business's financial environment. By making this determination, CMS calms the fears and concerns of many of those that may oppose this plan, while leaving wide open the door to anyone who may wish to participate (as well as those that do not, without fear of penalty).

Similarly, the recommending that, were a small business to purchase employer-sponsored coverage through the SHOP, then they would likely qualify to receive a tax credit for up to 50 percent of the employer's premium contributions toward employee coverage is an intelligent and generous proposal. This incentive is a reasonably acceptable "middle ground", whereby small businesses are able to offset a cost that many see as integral to maintaining a healthy and vibrant workforce, which reduces the likelihood of a disrupted workflow and reduced output and/or profit.

##### **b. Functions of a SHOP (§ 155.705)**

One item of disagreement, however, is the suggestion that the SHOP does not need to include the calculator described in § 155.205(c). While the authors of the rule are correct in stating that the same rules [for individuals] do not apply to the SHOP, it should be noted that the need of a calculator may ease the burden of paperwork/oversight to the benefit of the employer, making it more palatable to purchase coverage for businesses (especially those employing closer to 50 individuals). The authors of the rule do go on to state that they "encourage a SHOP to consider options to calculate and display the net employee contribution to the premium for different plans and different family compositions, after any employer contribution has been subtracted from the full premium amount", which is a very positive decision. Though this is a good suggestion, FACHC believes that this calculator should be mandated as a SHOP's QHP provider basic requirement, provided in a standardized "fill in the blank" format electronically on their website – or a specially designated website developed by CMS (or a similar entity) to which the SHOP's overseer is then required to link to their webpage and notify purchasers/employers of its existence and access to such.

FACHC is in agreement that the SHOP "[M]ust at a minimum facilitate the special enrollment periods described in § 156.285(b)(2)". It is presumed by FACHC that this requirement includes all special enrollment categories referred to in Section II(A)(4)(d), as § 156.285(b)(2) states "QHP issuers must meet the same requirements for the SHOP as the Exchange, along with the additional requirements prescribed in [Subpart 5]". To disallow the inclusion of these enrollment exceptions (or to not require them) would be unfair to employees and may result in the disenrollment in SHOPs, reduction of tax exemption(s) for employers and a negative impact on the SHOP program(s).

FACHC looks forward to the forthcoming decisions on further special enrollment periods alluded to in the rule, when CMS stated "We recognize that other laws (including, but not limited to HIPAA)...may require additional special enrollment periods and this proposed rule in no way eliminates those requirements".

Additionally, the two exceptions<sup>14</sup> noted in the proposed rule language directly linked to this section seem to be agreeable in nature to FACHC and would be supported in their current forms.

Further discussion of the specific enrollment periods can be found in a later section of this letter.

[A] qualified employer may choose a level of coverage..., under which a qualified employee may choose an available plan at that level of coverage [1312(a)(2)(A) of the ACAACA]...[W]e provide flexibility for Exchanges and their SHOPS to choose additional ways for qualified employers to offer one or more plans to their employees. For example, an Exchange may: (1) allow employees to choose any QHP offered in the SHOP at any level; (2) allow employers to select specific levels from which an employee may choose a QHP; (3) allow employers to select specific QHPs from different levels of coverage from which an employee may choose a QHP; or (4) allow employers to select a single QHP to offer employees.

FACHC interprets the statutory interpretation of [ACA] section 1312(a)(2)(A), which speaks to employer specification of a level of coverage to read similarly to the selection from the rule's text, as presented above. From the perspective of a small business, FACHC agrees with the options laid forth in the previous excerpt – with one exception. The Exchanges/SHOPS should not be granted the authority to make the selection on which of the four choices the small business will have in regard to providing employers and employees choice options. In other words, the four options is a move in the right direction, but the determination of which of the four options, as listed in the excerpt should, ultimately, be at the discretion of the small business employer. As each economic, social and geographic environment is dramatically different from one business to another – even in the same communities – it is imperative that the employer be given the penultimate opportunity to weigh their options, based on their individual and employee-base standings (financial, professional and/or general health status).

FACHC chooses not to respond directly to the second half of this particular request for comment, as our interpretation is that Section 1312(f)(2)(B) of the ACA, which may permit a single QHP selection by an employer, refers, in the law, to large employers, which is – by definition – outside of the scope of the Small Business HOP. However, if this rule is to be applied to a SHOP, on behalf of small business employers, then it is believed that the option should be made available for a single QHP to be offered to employees – but strongly recommended by CMS to said employers to provide for multiple plan options. To go further, the plan options may then be suggested to be at the discretion of the employees to choose what is best for the whole of the employed base in the single business – as has been presented to them by an individual from the QHP and/or SHOP that provides detailed descriptions and figures on costs and benefits within the optional plans.

One of the primary ideas behind an Insurance Exchange is that the pooled risk and multitude of buy-ins will lower costs and create economies of scale. Hence, in response to the request for comment, logic would presume that QHPs offered in the SHOP should be required to waive application of minimum participation rules at the level of the QHP or issuer, as a minimum participation rule applied at the SHOP level is not necessary. In theory, even one individual at a single small business can pool with numbers of individuals from other small businesses under the same QHP benefits and payments structure to create a pool that would justify its existence. The downside to this option is a potential for increased tracking and “keeping u with” of QHP recipients, but with the current technological situation of medical records and electronic billings, this should not present any new problems beyond what is currently being experienced.

CMS proposes that the SHOP allow qualified employers to receive a single monthly bill for all QHPs in which their employees are enrolled and to pay a single monthly amount to the SHOP. CMS requested comment on the suggestion as to whether they [CMS] should allow a more permissive or restrictive timeframe than monthly, quarterly, or annually. It is recommended by FACHC that the structure of the payment timeframe be negotiable between each business entity and each QHP and/or SHOP [i.e. contracting entity]. The decision should be made on a case by case basis, as is determined to be the timeframe of best fit by the two entities. Most likely, the small business will elect to pay a monthly amount – as it allows for better planning and does not result in a single, large deduction from capital and/or reserves (as does the annual payment). However, depending on the nature of the business, some may wish to pay this cost all at once and up front, while their finances are the most robust – perhaps a business that relies upon a given holiday for their peak revenue earnings.

CMS suggests that, if an employee is hired during the plan year (or changes coverage during the plan year during a special enrollment period), then the rates set at the beginning of the plan year must be the rates quoted to the employee. CMS then requests comment, it is believe, as to the applicability to this rate, or if this rate should be provided as something different. In regard to protecting the consumer, the rate quoted to an employee who is eligible to sign up for or adjust their coverage through

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<sup>14</sup> (1) Because non-lawfully present individuals employed by a small business are not eligible for the SHOP, there would be no special enrollment period associated with becoming a new citizen, national, or lawfully present individual for the SHOP

(2) There would be no special enrollment period in the SHOP to reflect a change in eligibility or new eligibility for advance payments of the premium tax credit or cost-sharing reductions since neither is available to qualified employees in the SHOP.

their employer should be no more and no less than that rate agreed upon by the employer and the Exchange/QHP issuer upon the employer's annual reenrollment period or initial enrollment – whichever has most recently transpired. Hence, the QHP should not be amended by the Medical Expense Inflation (MEI) rate<sup>15</sup> outside of the employer's once-a-year QHP decision period (new coverage and annual renewals).

### c. Eligibility Standards for SHOP (§ 155.710)

CMS has provided the respondents to this proposed rule a rather wide scale to determine the proper level of employment base to be deemed appropriate for SHOP participation. To quote:

“Specifically, the employer must employ no more than 100 employees, with the exception that a State may elect to limit enrollment in the small group market to employers with no more than 50 employees until January 1, 2016.”<sup>16</sup>

Internally, FACHC staff numbers a mere 11, and, thus, would likely qualify for the SHOP under either premise. However, FACHC finds that a small business employer can, indeed, range from a handful to dozens – as many of those Centers [FQHCs] that we represent would fall both inside and outside of the proposed figures.<sup>17</sup>

It is with this reality that the concept of “small business employee maximum” is brought into question in the light of FACHC's response. FACHC members' FTE bases range from as low as 7.20 FTEs to as high as 531.66 for 2010. Roughly 50 percent of our members would qualify for the “100 FTE level”, whereas about 75 percent would not qualify for the “50 FTE level”.

Regardless of this difference, both Centers, whose FTEs were specified, should qualify as small businesses. Perhaps the definition of small business should be more specific than simple FTE counts, as one person may describe a small business as one which remains within a small geographic area, employs from the local population and earns a certain range of profit at the end of the year. Those businesses that employ 250 individuals from a local community, serve the poor within the local community and often receive little or no compensation for care may be the most in need of the small business tax refund incentives in order to be able to provide their own employees with the services they, themselves, are providing.

Therefore, FACHC believes that consideration in addition to FTE totals should be implemented in the determination of small business eligibility.

Due to the nature of the members FACHC represents, we stress strong support for the following proposed language:

[W]e propose that the employer can elect to cover all employees through the SHOP serving the employer's principal business address. An employer with worksites in different SHOP service areas can elect to offer each eligible employee coverage through the SHOP serving the employee's primary worksite.

The FQHC structures in Florida are many, ranging from a single location to several within one county [e.g. Miami-Dade] or even some that are based in rural communities across an entire geographic region within the state [e.g. North Florida Medical Centers, Inc.]. Due to this reality, FACHC supports the proposition that an employer be given the leeway to utilize one main SHOP to provide healthcare coverage for their entire employee base. FACHC would recommend that, in the finalized language, this opportunity be limited to only those SHOPS that are offered in the individual FQHC organization's “home county” or “home region” – whichever is determined by the state or SHOP developer [in Florida's case, originally the Secretary]. By limiting the option with this exception will allow for easier administration within the FQHC and the SHOPS. However, it would also be recommended that this option not be a requirement of those small businesses that may be within multiple “areas” and that the option to allow each location – in “areas” not those of the central location – be allowed to choose SHOPS independently, if the FQHC organization deems such to be in their best interests.

FACHC is in favor of the proposed language that SHOP be required to accept the application of an employer to provide coverage

<sup>15</sup> This figure should be discussed and a source/algorithm should be agreed upon by a panel of healthcare experts, laying out the definitive, allowable legal ceiling for increase in costs to a consumer. One such example of this is the [US Bureau of Labor Statistics' Consumer Price Index for Medical Care](#)

<sup>16</sup> The definition of an employer – and, as such, size thereof – is being suggested to be defined as per the standards outlined with the PHS Act, ERISA and Section 1304 of the ACA...according to the published rule proposal text, these are all reliant upon the size of the workforce, as determined by FTE calculations.

<sup>17</sup> [T]he calculation of an employer's size based upon the average number of employees employed on business days during the preceding calendar year...[D]etermines employer size by counting all employees, including part-time and seasonal employees, to determine an employer's size. Part-time workers would be counted in the same manner as full-time workers, while seasonal employees would be counted proportionately to the number of days they work in a year ... [D]efinition of group health plan refer to at least 1 employee, they exclude sole proprietors, certain owners of S corporations, and certain relatives of each of the above... States [may] use a variety of methods to determine employer size with regard to eligibility for participation in the small group market, and that these State methods may, in turn, add a level of specificity not described in this method of determining employer size.

to eligible employees whose worksite is in the SHOP service area, if the employer elects to cover all employees through the SHOPS serving their worksites. This is to say that the SHOP should not be allowed to deny an employer's application for coverage in their SHOP plan based on anything outside of predetermined, legitimate reasons<sup>18</sup>.

[A]llows an employer participating in the SHOP to continue participating in the SHOP if the number of workers employed exceeds the level specified by the definition of a qualified employer after the employer's initial eligibility determination.

#### **d. Eligibility Determination Process for SHOP (§ 155.715)**

FACHC finds that the eligibility determination examples provided in this section<sup>19</sup> are reasonable and fair. However, it is somewhat concerning in the text that states that those listed may include, "but are not limited to" those options listed. It is imperative that this list be fully vetted and publicly reviewed prior to finalization. There may arise a need for special exemptions or further clarifications that should not need to be revealed in hindsight – at that point it may result in a lack of coverage for numerous businesses for an unnecessarily lengthy timeframe, due to a number of events, including, but not limited to, a minimal number of SHOPS offered in that/those business(es) areas.

FACHC applauds CMS' proposal to require written and specific notification to employers rejected from coverage by SHOPS. By so doing, it allows employers to reconsider their application and/or make changes, as deemed necessary by the QHP issuer. Similarly, it is encouraging to see the intent by CMS to further protect the consumer by suggesting the requirement that the SHOP make a reasonable effort to identify and address the cause of the doubt [that led to rejection]; contact the employee or employer to confirm the accuracy of relevant information and provide the employee or employer with a 30-day period to correct the possible error and then must notify the employee or employer of determination. The intent of the ACA is to encourage individuals – and, in this case small businesses – to acquire health insurance coverage; these requirements upon SHOPS can act as a significant safeguard on behalf of these entities that will work towards a greater number of Americans being covered.

It is also encouraged by FACHC that this notice must inform the employee about his or her eligibility for special enrollment periods in the Exchange and about the process of being determined eligible for advance payments of the premium tax credit and cost-sharing reductions, Medicaid and CHIP. Similar to current case managers and enrollment specialist that can now be found at FQHCs nationwide, this opportunity being provided to SHOP participants and/or individuals will also work towards an expansion of coverage and an increase in healthy outcomes – while decreasing healthcare and premium costs.

#### **f. Enrollment Periods Under SHOP (§ 155.725)**

FACHC supports CMS' proposed language<sup>20</sup> regarding open and rolling enrollment dates and that employers be held to the same level of accountability as other parts of the Exchange rule, as complicating the process would lead to confusion and a lack of clarity on behalf of QHP issuers, employers, employees and individuals alike.

However, the limitation placed on employee plan adjustments in this subsection<sup>21</sup> may require further discussion or complete exclusion. Such an exclusion from the ability to amend a person's insurance plan may lead to a gap in coverage or inadequate coverage, which may lead to significant financial hardships or negative health outcomes. This concern may be dismissed if, as has been alluded to in the language, exceptions are guaranteed that mirror those of special enrollment rules as well as the There should be an opportunity for an employee to state their case for their need for coverage or plan changes on an individual level and be afforded opportunity to have a process for review and recourse, should an employee be denied a change., with considerations and acceptance of business realities given on behalf of the QHP/SHOP issuer to whom the request was addressed.

FACHC is in agreement with the proposed CMS language that, consistent with current market practice, an employer's plan year may not necessarily align with the calendar year and that plan years inside the SHOP should consist of the twelve-month period beginning with the employer's effective date of coverage. New businesses open at different times of the year and to disallow an

<sup>18</sup> These reasons would need to be developed, through consultation with experts throughout the healthcare community and be based on ideas such as equal opportunity and anti-bias, as well as business concerns that include an employer being determined ineligible or having been previously found to have engaged in illegal or unethical activities by an authoritative source. Examples of such business concerns and determination restrictions/guidelines can be found in the text within this proposal in II(A)(5)Subpart H(d).

<sup>19</sup> Review of quarterly wage reports suggesting the employer does not meet the State's definition of a small employer; and attempts by an employer to enroll a number of employees that is greater than allowed under the State's definition of small employer, contrary to attestations made on the application

<sup>20</sup> Adhere to the start of the initial open enrollment period for the Exchange and ensure that enrollment transactions are sent to QHP issuers and that such issuers adhere to coverage effective dates in accordance with § 156.260... We propose that the initial open enrollment for the SHOP begins on October 1, 2013 for coverage effective January 1, 2014 ... [W]e propose a rolling enrollment process in the SHOP whereby qualified employers may begin participating in the SHOP at any time during the year...

<sup>21</sup> [W]hile a qualified employer may enter the SHOP at any time, the qualified employees will only be able to enroll or change plans (to the extent multiple QHPs are available) once a year unless such employees qualify for a special enrollment period.

application to a SHOP for coverage would prove irresponsible and detrimental to the small business<sup>22</sup>.

It is wise of CMS to suggest an “annual employer election period” prior to the annual open enrollment period or renewal of SHOP coverage by employers, during which time a qualified employer may modify the employer contribution towards the premium cost of coverage and plan offerings, among other things. It is imperative that the phrase “among other things” be fully vetted and publicly reviewed prior to finalization. To allow employees the same, or similar, option (during which time the employee is granted the freedom to change plans) is also a favorable proposition put forth by CMS.

It is also a good decision on the part of CMS to suggest the requirement that employers receive a notice in advance of an impending election period – a renewal notice, if you will. Though the concept is quite valuable to the continuation of coverage, the renewal notice may be better utilized if it is provided to the employer both 60 and 30 days in advance of the time period. CMS suggests a 30 day notice, but this may not, among other things, provide sufficient time to plan and project financial availabilities on behalf of the employer. Furthermore, by providing employees with this length of time, they will be given more ample time to weigh their own options and (if fortunate enough to be in such a position) consult with another individual/dependent, qualified through their own employer’s SHOP or QHP offering to determine if the continuation of coverage under the current employer’s plan is more or less advantageous to the fiscal and physical health of the employee’s “coverage unit”<sup>23</sup>.

CMS’ rule language, which proposes that the SHOP ensure a qualified employee who is hired outside of the initial or annual open enrollment period the opportunity to have a specified window set by the SHOP to seek coverage in a QHP beginning on the first day of employment, is an admirable start. However, there should be a predetermined, regulated length of time for this activity. For example, an employee should be granted 45 days upon employment to complete their open enrollment period. A concern – though it may be illegitimate and/or unnecessary – exists that the new employee may be subject to a rule, determined by the SHOP, that this window of time is insufficient or less than a reasonable length.

Again, the conclusion of this part of the rule’s text is appropriate for the current landscape, as it is developing. This language states that, at the time of the annual open enrollment period, the employee would have the option to renew or change coverage on a similar basis as the other employees of that qualified employer covered through the SHOP. By so requiring, CMS ensures that an employee will be provided the opportunity to find the plan of best fit to their environment<sup>24</sup> in a timely and reasonable manner.

#### **g. Application Standards for SHOP (§ 155.730)**

FACHC agrees with the CMS suggestion for application standards<sup>25</sup>. However, the inclusion of sensitive information, such as employee social security numbers, should not be required. If an employer is applying to more than one SHOP, then by sharing this information, the employees will be exposed to unnecessary risks that are not necessary to make determinations of eligibility. FACHC understands concerns about attempts to cover illegal immigrants and other similar concerns (i.e. ineligible individuals), but the safety and security of individual employees should trump this concern. This information can be provided upon pre-approval by a SHOP and determination by an employer that said SHOP will be the plan(s) offered to said employer’s employees.

#### **Section II(B)(2)(o) Additional Standards Specific to the SHOP (§ 156.285)**

In general, QHP issuers must meet the same requirements for the SHOP as the Exchange, along with the additional requirements prescribed in this section, **Section II(B)(2)(o) Additional Standards Specific to the SHOP (§ 156.285)**. For example, since the SHOP allows qualified employers to enter the SHOP on a rolling basis, QHP issuers may establish new rates on a quarterly or monthly basis in accordance with SHOP standards. FACHC disagrees with this premise, to the extent that employees that enroll in an employer’s QHP during a special enrollment period should be allowed to do so at the rate agreed upon by the employer at the time of the employer’s initial enrollment. For purposes of rolling *new employer* enrollments, it seems agreeable that the rates be allowed to be updated more often than on an annual basis. Stated another way, it is not recommended that actively enrolled employers be subject to rate changes more often than annually; though the QHP should be allowed to update its rates more often for the purposes of new employer (not employee) enrollments and/or annual employer renewals.

<sup>22</sup> The small business would possibly suffer in offering the best benefits to attract the most skilled labor force available; as well as the lack/restriction of healthcare options for potential employees, which would have the potential of leading to negative health outcomes and unnecessary fiscal repercussions.

<sup>23</sup> By coverage unit, it is meant to say any grouping of dependents that comprise those qualified to be covered by an individual employee’s health plan. Most likely, the common term is referred to as a “family unit” – however, this may not be inclusive of all instances of this concept.

<sup>24</sup> In the event that the initial open enrollment period is not sufficient for an employee to make an informed decision or if an employee’s personal environment changes during the time between initial and annual enrollment periods and does not qualify for any special enrollments or other exceptions that may qualify her or him to change their plan

<sup>25</sup> (1) Employer name and address of employer’s; (2) Number of employees; (3) Employer Identification Number (EIN); and (4) List of qualified employees and their social security numbers

CMS also considers and requests comment on whether to require QHPs in the SHOP to allow employers to offer dependent coverage. FACHC would promote this requirement, as it would be favorable to the employee, the risk pool and the employer – as this is a highly desired benefit that would enhance the employer’s capability to hire the best and the brightest for the position, as a result of a more robust applicant base. There may be a necessity to include higher premiums for the privilege of covering dependents under a given plan. Such differences must be required to be noted during enrollment discussions.

## I. Other Issues of Interest to FACHC Within the CMS Proposed Rule CMS-9989–P

**Section II(A)(2)(g)** of the proposed rule proposes that a State may establish one or more subsidiary Exchanges, if each such Exchange serves a geographically distinct area. The area served by a subsidiary Exchange must be at least as large as a rating area described in section 2701(a) of the PHS Act, and referenced in section 1311(f)(2)(B) of the Affordable Care Act<sup>26</sup>. It also suggests the option to establish a Regional Exchange or Subsidiary Exchange (§ 155.140), wherein, the operation of an Exchange in more than one State if each State permits such operation and the Secretary approves such an Exchange. It is also proposed by CMS that the States need not be contiguous.

FACHC finds initial support of the concept of regionally-distinct HIEs. By so allowing, CMS opens the door to more specific, coordinated and focused care. With the ability to regionalize care, the QHP issuer is granted the ability to assess the particular healthcare concerns within a community – either on a small or wide-ranging scale. The ability to conform QHP offerings to a region and coordinate practitioners within an area that is of a more reasonable size and distance will, in theory, promote better healthcare outcomes, as multiple small communities, through which various specialists may be scattered, will be brought together under a single umbrella.

It should be recommended that the Secretary ensure that the “region” within which the Exchange has decided to offer QHPs is reasonable to those with minimal resources. For example, allowing an Exchange to take root within a single urban community may be more reasonable than allowing the QHP to be stretched across twelve rural counties – whereby an individual may not be able to traverse the significant distance between specialists due to a lack of transportation or financial ability. This may be somewhat alleviated, however, by putting into place a number of requirements on the Exchanges – such as their allowances for providing transportation for beneficiaries or financial assistance or reimbursement for the costs incurred as a result of the Exchange’s decisions to include such a significant swath of acreage under its plan, knowing the availability of and distance between patients and certain specialists or other practitioners.

In addressing the multi-state Exchanges, it is believed that this may be a very successful idea. Caution must be taken, though to determine – prior to approval of the Exchange by the Secretary or any states – the socio-economic and healthcare climates within the proposed Exchange. For example, it is imperative that the two “locations” (be they regional, statewide or other) resemble each other and such should be documented – however extensively should be determined by the Secretary and/or CMS. For example, it would be unwise to offer the same health plan within a high-poverty, rural area as is offered to a well-to-do, suburban community. Though an Exchange may choose to offer a buffet of QHP offerings, if there is any limit on options – or the opportunity to coerce individuals into purchasing coverage that would not be to their advantage financially or necessary in light of their personal and community’s healthcare environment – the Exchange may not be as well-coordinated or well-received within those communities (among other things).

Ultimately, coverage and proper, adequate and appropriate care are the goal of the law and the intent of the rule. Therefore, every caution and consumer protection should be intertwined into this rule to ensure that those goals are achieved.

If FACHC is correctly interpreting the proposition found in **Section II(A)(2)(i)** Financial Support for Continued Operations (§ 155.160), CMS is proposing the allowance of a tax on individuals for the right to have healthcare coverage. This is meant to say that, under other sections of this rule, CMS is proposing monthly costs be paid by employers and/or employees, as well as co-pays for care – and this “annual premium”<sup>27</sup> would be equivalent to a credit card fee charged for the privilege to rack up debt and get charged interest on it.

**Section II(A)(3)(b)(4)** discusses the requirement that Exchanges develop an electronic calculator to assist individuals in

<sup>26</sup> (2) RATING AREA.— (A) IN GENERAL.—Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this title. (B) SECRETARIAL REVIEW.—The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State’s rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

**TITLE XXVII-PUBLIC HEALTH SERVICE ACT: SEC. 2701. f 42 U.S.C. 300gg~ FAIR HEALTH INSURANCE PREMIUMS**

<sup>27</sup> A State Exchange must be self-sustaining by January 1, 2015; the statute explicitly lists assessments and user fees on participating issuers as one potential means for a State to secure operational funding for Exchanges...States may use broad-based funding (which may include general State revenues, provider taxes, or other funding that spreads costs beyond imposing assessments or user fees on participating issuers), as long as the use of such funding does not violate other State or Federal laws...We invite comment on whether the final regulation should otherwise limit how and when user fees may be charged, and whether such fees should be **assessed on an annual basis**.

comparing the costs of coverage in available QHPs<sup>28</sup>. FACHC fully endorses this concept and encourages the promotion of and required utilization of such a tool by any user of an Exchange or care coordinator/"Navigator" that works with the beneficiary to become enrolled in an Exchange. An educated consumer is a savvy consumer – and a consumer that will take more personal responsibility, ownership and pride in making their own healthcare choices. By offering the ability to better understand the costs of the services and plans offered, an individual can better comprehend the repercussions of electing to include a particular coverage option in their plan or not.

CMS requested comment to this issue – the calculator – in regard to the benefits the state would receive. The previous points, stated in the prior paragraph would be reiterated in this response. By creating savvy consumers and enhancing knowledge of costs and offered services, the consumer will save the state costs, as they will be more likely to receive primary, preventive care than to allow the symptoms to linger and incur greater costs from a condition that could have been treatable or manageable.<sup>29</sup>

FACHC finds a small reason for concern in CMS' rule language in **Section II(A)(3)(c)**, wherein it is proposed that the general standard that Exchanges must award grant funds to public or private entities to serve as Navigators. More specifically, CMS seeks comment in regard to Section II(3)(c)(3) regarding whether they should require that at least one of the two types of entities serving as Navigators include a community and consumer-focused non-profit organization, or whether we should require that Navigator grantees reflect a cross section of stakeholders. FACHC is concerned that, should there be a limited, established number and specific set of Navigators, access to adequate resources in making decisions regarding care, on behalf of the individual beneficiary/purchaser, may be negatively impacted. By limiting the contracted or grant-awarded Navigator entities, it may result in duplication of effort (among healthcare providers and contracted entities) and/or an associated reduction in service, as well as the potential for individuals to be required to double the efforts, contacting an entity outside of the currently established "navigator" resource – in the case of FQHCs, in particular<sup>30</sup>.

Perhaps an agreeable solution to a potential, unforeseen pitfall within a well-intended goal would be to give States the freedom with which to make the determinations as to payment for the "Navigator" service(s). For example, a State could provide a base grant, as is the currently proposed option; however, another option may be to provide for a per person counseling rate<sup>31</sup>. It would be imperative to pre-determine and pre-qualify individuals and/or providers to participate as Navigators.<sup>32</sup> By so doing, the discretion would be given to States to be responsive to individual regions and local concerns in ensuring and holding accountable Exchanges and QHP issuers.<sup>33</sup>

Further making a case on behalf of utilizing current resources within FQHCs for the Navigator program, CMS proposes in **Section II(A)(3)(c)(8)** that a Navigator must provide information in a manner that is culturally and linguistically appropriate. As part of every FQHC 330 grantee's basic functions, culturally-competent service provision is a "strongly encouraged" capability. FACHC is in agreement with CMS' proposal that any entity that wishes to become a Navigator should be required to be culturally and linguistically competent, as per no less than the top three languages and populations in the designated Exchange area.

In response to **Section II(A)(4)(b)** Single Streamlined Application (§ 155.405), FACHC finds that it would be advantageous and diligent if the Secretary require all applicants applying for advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP, and the BHP, if a BHP is operating in the Exchange service area be required to answer questions that are not pertinent to the eligibility and enrollment process. Although it is understood that there may exist a desire to minimize reporting requirements to better ensure participation, it is not worth the potential loss of valuable information and care to do as has been suggested.

Though a part of the intent of the rule, as written, is to be structured to maximize an applicant's ability to complete the form satisfactorily, it would seem more intuitive to require the information up front, thereby negating any potential delays. For example, should the individual or entity applying determine for themselves that they need not provide a particular item of information and then, upon review by an authoritative entity, it is determined that such information is pertinent to said application, then the delay

<sup>28</sup> After the application of any advance payments of the premium tax credit and cost-sharing reductions

<sup>29</sup> It must be recognized that this is, in no way, a universal truth. Not every beneficiary will take advantage of these opportunities for care, regardless of recognition of cost to themselves and others. However, it can be presumed, using FQHC encounter per patient historical data as a reference, that the more informed of opportunity to receive high-quality care a person is, the more often and more likely they are to seek out and utilize that resource.

<sup>30</sup> It is a current practice of FQHCs to act as "Navigators" in their own right, working with patients to find coverage – be it through Medicaid/Medicare enrollment or simply working with a private insurer to allow for coverage of an individual's procedure.

<sup>31</sup> This is often referred to as either a case management fee or a per member per month fee – depending on the structure of the program for which reimbursement is being paid, as well as the level of recurring cost for the service provided.

<sup>32</sup> This oversight would require a small funding stream be provided directly to the State (or oversight entity) to provide for the cost of overhead, technology and accountability functions.

<sup>33</sup> In some States, initially, the Secretary may be responsible for the creation and oversight of the Exchanges in the first few months. The Secretary (or the duly assigned body to act in her stead in such a role) would be granted this authority of oversight and would determine criteria and necessary application forms through which individuals and/or providers would apply to take on the responsibility to act as Navigators.

could lead to a lapse or gap in coverage that may result in more serious fiscal or health concerns. Additionally, should the standardized form, with standardized information requests be filled out in its entirety, the ability of those that may choose to review the program (for participant population data, assessment of applicability and improvements via best practices, etc), it would be more valuable to have a complete data set from which conclusions may be drawn (from the national down to the census tract block levels) than to have only a partially complete data set from which inferences and presumptions must be made.

Similarly, should an individual choose to take a tax exemption on their annual federal income tax return form to the IRS, it is required that they fill out all necessary paperwork and provide all information – should they desire to receive the benefit. This exemption is not a required activity and, thus, does not require the submission of information if the person chooses not to take advantage of it. However, should a person choose to take any such tax break and they neglect to provide the entire required information and documentation, then they are either audited, denied the benefit for which they may actually qualify or are contacted by the IRS and informed of the error, then allowed to amend their submitted return and receive the exemption as originally intended. Regardless of which of those three listed options is the case, the most significant fact is that the individual did not receive their benefit in a timely manner – or the manner originally intended by the rule and/or law. Hence, by allowing the applicant to only provide *some* of the information, the rule may be in violation of the intent of the law.

Also noteworthy of comment, as requested by CMS, in **Section II(A)(4)(b)** Single Streamlined Application (§ 155.405) is that it is suggested within the rule that the Exchange must accept applications from multiple sources, including the applicant; an authorized representative (proposed to be defined by State law); or someone acting responsibly for the applicant. For no other reason than the creation and utilization to the greatest extent and value possible of Navigators, this proposed text of this rule should be codified. In addition to this perspective, it would be most wise to allow, at a minimum for purposes of those who may be handicapped or disabled, the ability to be represented by an individual and, as such, allow them to apply on their behalf. It should also be specified that the Navigator cannot apply on behalf of the individual without the signed consent of an individual or an individual's parent, guardian, court-designated representative or legally approved family member to aid in the assurance that the decision was made using the best information available and – most importantly – was in the best interests of that individual (and/or any individuals that may be dependents of the said individual).

In the same Section, **Section II(A)(4)(b)** Single Streamlined Application (§ 155.405), it is proposed that an individual be able to file an application online, by telephone, by mail, or in person. FACHC is in agreement with this proposal, as many of the member Centers' patients can personally attest to the difficulty of the availability of resources in regard to transportation and communications. To deny one of these three forms of submission would be to deny access to a large population of low-income, or otherwise resourcefully impaired, Americans.

**Section II(A)(4)(c)(3)** presents a very sensitive suggestion and situation. CMS has suggested that individuals who received advance payments of the premium tax credit and are then disenrolled<sup>34</sup> from a QHP because the QHP is no longer offered if such individual does not make a new QHP selection be automatically enroll by their current Exchange. The solution to this situation may take one of several forms.

First, the solution may be to require an individual to return or somehow reimburse any costs related to the advanced payments. This may be triggered by a designated time frame lapse (e.g. 60-day period), during which the individual did not reenroll. This may also initiate the process to restart, thus requiring resubmission. This would be the most punitive reaction and would be least preferred.

The second option would be to automatically reenroll them in a QHP within the Exchange. Individuals may not be as pleased with this coercion to join a plan with which they may not be familiar – or simply the fact that they were not given a choice. Similarly, the plan may not be suitable to the enrollee's needs and may result in complications of receiving necessary healthcare. This option, were it the one on which CMS ultimately decides as the correct one, must include a set of requirements and notifications be placed on the Exchange and QHP in order to be acceptable. For example, the assigning entity must be required to notify the individual of their disenrollment as soon as possible – this requirement either being accompanied by a 60-day minimum notification timeframe [60 days prior to the plan no longer being offered] or, if this timeframe is not feasible, then a requirement of guaranteed coverage until such a time that an adequate plan (which suits the needs of the enrollee) can be identified and into which the enrollee can be enrolled. Another example of a requirement would be for the Exchange to guarantee, at minimum, the same level of coverage for the same cost to the enrollee and work (either through a Navigator or another similar entity) to guarantee reenrollment.

A third option (though three options are in no way fully exhaustive of all possibilities) could be that the Exchange simply be required to fulfill the duties outlined in the previous paragraph, excluding any automatic reenrollment, simply making all reasonable efforts to reenroll the enrollees who had been disenrolled by a QHP by no fault of their own.

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<sup>34</sup> It is assumed that this lack of coverage of an individual by a given QHP is by no fault of their own

On a similar line of thought, it may be acceptable that, should an individual be disenrolled by their own actions, or as a result of their own actions, the contract with the Exchange and/or QHP would be severed and the Exchange would no longer be required to guarantee any such healthcare service. It would be under this premise that the enrollee would then be responsible for making the reasonable efforts to reenroll and work with Navigators, finding a plan that best suits their needs. The Exchange would not be obligated to provide the same services at the same cost if the QHP was no longer offered or if a reasonable amount of time between initial enrollment and reenrollment has lapsed. By this last statement, it is meant to suggest that the price for the same buffet of services may have increased with time and, thus, the appropriate level of increase should be acceptable to CMS.

Outside of an individual being disenrolled as a result of their own actions, an Exchange and/or a QHP must be required to diligently, within reason, work with the disenrolled individual to find a reenrollment QHP.

FACHC applauds the foresight recommended in **Section II(A)(4)(d) Special Enrollment Periods (§ 155.420)** by CMS through its alternatives for the special enrollment periods. The inclusion of this provision is necessary to aid in the fulfillment of the intent of the ACA, working towards ensuring fair and affordable coverage to all Americans. A number of those persons specified in the proposed rule should not be punished for the circumstances in which they find themselves trying to acquire healthcare coverage (e.g. error in enrollment, gaining citizenship, permanent move or birth). Though no specific additional examples of special enrollment periods can be provided at the time of the writing of this response, it is largely encouraging to support CMS' suggestion in which they recommend "exceptional circumstances", as determined by the Exchange and/or HHS<sup>35</sup>. It is imperative to have this open-ended eventuality in the list; however, it may be valuable to add entities to the list of those who are eligible to approve a special enrollment period as a result of exceptional circumstances (e.g. the President of the United States, the Governor of a State or a State healthcare agency – such as the Florida Agency for Health Care Administration, or AHCA).

CMS also seeks comment on this subsection of the rule, **Section II(A)(4)(d) Special Enrollment Periods (§ 155.420)** by asking whether States might consider expanding the special enrollment period to include gaining dependents through other life events. This idea is promising, though it cannot be supported without further specification and allowance for public comment.

Further in the subsection, **Section II(A)(4)(d) Special Enrollment Periods (§ 155.420)**, CMS requests comments as to whether the start of the 60 day special enrollment period should be based on the date on which an individual experiences a change in eligibility or based upon the date of the eligibility determination. The 60-day timetable should benefit the enrollee and, thus, should begin upon the determination of eligibility. However, it should be included within the final rule that the Exchange/QHP should, within reason, make every attempt to work with the potential enrollee to determine, as early as possible – including, but not limited to the time period prior to actual eligibility determination – and determine the QHP of best-fit for the applicant. In so doing, the Exchange/QHP would enable almost instantaneous coverage (all other circumstances allowing) for the applicant upon approval of their eligibility. As further requested by CMS for comment, the employee(s)' 60-day time frame should also begin at the time that most benefits the consumer – likely to be upon the termination of the coverage by the employer in this case, unless documentation can be provided wherein it can be proven that the employer (and the Exchange/QHP issuer) neglected to notify her/his employees of such an event (loss/change of coverage) and neglected to inform the employee until a date that was later than that which would be the initiation of the 60-day period to find a new QHP.

CMS proposes later in this subsection, **Section II(A)(4)(d) Special Enrollment Periods (§ 155.420)**, that, upon qualifying for a special enrollment period, the Exchange may only allow an existing enrollee of a QHP to change plans within levels of coverage. The example provided in the rule's text is of an enrollee that is in a silver level plan, who gives birth to a child outside of the annual open enrollment period, is allowed to add the child to her existing plan or change from one silver level plan to another – but is not permitted to move to a gold level plan. CMS recognizes that limiting enrollees such that they must stay within a specific coverage level during a special enrollment period could pose a challenge for an enrollee in a catastrophic plan that becomes pregnant – as one example. This circumstance is only one of many that may fall within the previous (and potentially additional, currently unknown) special enrollment periods, but serves as a prime reason for the ability to amend coverage during a plan year prior to renewing/reenrolling during the annual period, during which this is generally acceptable, as per the proposed rule's guidelines.

It would be recommended, however, that this proposal be amended in such a way that the individual be granted permission to change levels within the same QHP. Rather than allowing a shift at the same level across different plans, the rule should be written to where the enrollee be required to stay within their current plan, but adjust it to include the circumstances that bring about the special enrollment period. By writing the rule in such a way, the individual would be provided with further self-responsibility and require greater planning and thought towards current and potentially future healthcare circumstances. Also, in writing the rule, CMS should consider the inclusion of requirements on Exchanges/QHPs – or their representatives in the enrollment capacity, such as Navigators – to include discussions and scenarios (including the utilization of the aforementioned calculator) concerning the potential future healthcare occurrences as a part of the enrollment process.

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<sup>35</sup> Exceptional circumstances, include those events outside an individual's control; e.g. acts of God

**Section II(A)(6)(f) f. Establishment of Exchange Network Adequacy Standards (§ 155.1050)** proposes that each Exchange ensure enrollees of QHPs have a sufficient choice of providers, including additional minimum qualitative or quantitative standards<sup>36</sup> for the Exchange to use in evaluating whether the QHP provider networks provide sufficient access to care. FACHC supports the idea of including these standards within Exchange and QHP qualifications. Further, CMS' proposal to establish/include specific standards under which QHP issuers would be required to maintain a number of additional criterions<sup>37</sup> would foster greater consumer protections and guarantees to enrollees concerning access to care. CMS specifically makes note of medically underserved areas (MUAs), in which FQHCs are often found – and required to be in, as a condition of establishing a new location. FACHC agrees with CMS concerning the necessity of this inclusion within the final rule and/or code – if in no other instances than those Exchanges/QHPs within, and in regard to, MUAs and MUPs<sup>38</sup>.

FACHC supports the CMS proposition in **Section II(B)(2)(f) Essential Community Providers (§ 156.235)**<sup>39</sup> that QHP issuers be required to include in their provider networks a sufficient number of essential community providers, where available, that serve low-income, medically-underserved individuals. Should an Exchange's region – the land area, as determined by the oversight entity, such as the State – include such a population, it is imperative to require QHPs to include for those populations. However, should an Exchange's region not include such a population, then an exception should be written into the rule that allows for such a guideline to be excluded from that given Exchange's requirements.

CMS' consideration to establish broad contracting requirements wherein QHP issuers would have to offer a contract to all essential community providers in each QHP's service area – or establishing a requirement for issuers to contract with essential community providers on an any-willing provider basis – [is addressed in a different section of this response](#), which relates to FQHC reimbursements. However, as this topic is also addressed in this subsection, **Section II(B)(2)(f) Essential Community Providers (§ 156.235)**, FACHC will again address this concern and CMS' request for comment. In the previous section of this response, it is suggested by CMS that this requirement is optional. However, it may be valuable to include this requirement in the regions of the State in which Exchanges are operating in MUAs and/or MUPs.

FACHC recommends, in response to CMS' request for comment on how to define “a sufficient number of essential community providers” in **Section II(B)(2)(f) Essential Community Providers (§ 156.235)**, that CMS cite the Health Resources and Services Administration (HRSA) Need for Assistance (NFA) worksheet<sup>40</sup> as the source for standards. This worksheet addresses a variety of concerns that impact access to care by MUPs (or those in MUAs), including, but not limited to, an adequate number of practitioners to serve the designated population(s). Other topics considered by the worksheet address healthcare disparities and barriers to care. As to the request for comments regarding plans that may be allowed to exclude this requirement in its development and offering of plans and services, FACHC cannot recommend any instances in which it would not be pertinent to the consumer to mandate the inclusion of such a requirement in all QHPs as a condition of becoming qualified (outside of the lack of such populations residing in a given region, as mentioned previously).

**Section II(B)(2)(g) Treatment of Direct Primary Care Medical Home (§ 156.245)** speaks to the primary care medical home (PCMH) model that has proven to reduce, or create an environment of beneficial, costs (for the insurer, the insured and the practitioner) and improve services. CMS interprets the PCMH to mean an arrangement where a fee is paid by an individual, or on behalf of an individual, directly to a medical home for primary care services<sup>41</sup>, consistent with the program established in

<sup>36</sup> “...[N]etwork adequacy standards: States' particular geography, demographics, local patterns of care and market conditions.”

<sup>37</sup> (1) Sufficient numbers and types of providers to assure that services are accessible without unreasonable delay; (2) arrangements to ensure a reasonable proximity of participating providers to the residence or workplace of enrollees, including a reasonable proximity and accessibility of providers accepting new patients; (3) an ongoing monitoring process to ensure sufficiency of the network for enrollees; and (4) a process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider is accessible for that benefit in a timely manner

<sup>38</sup> Medically underserved populations; see also <http://bhpr.hrsa.gov/shortage/index.html>

<sup>39</sup> In § 156.235, [CMS] propose[s] to codify Section 1311(c)(1)(C) of the Affordable Care Act, which requires that a health plan's network include essential community providers who provide care to predominantly low-income and medically-underserved populations to be certified as a QHP. As specified in Section 1311(c)(1)(C), essential community providers include entities specified under Section 340B(a)(4) of the PHS Act and Section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 211 of Public Law 111–8.

CMS defines essential community providers to include all health care providers defined in section 340B(a)(4) of the PHS Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act

(IV) An entity that—(aa) is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Act or is State-owned or operated; and (bb) would be a covered entity described in section 340B(a)(4) of the Public Health Service Act insofar as the entity described in such section provides the same type of services to the same type of populations as a covered entity described in such section provides, but does not receive funding under a provision of law referred to in such section; see

[http://www.ssa.gov/OP\\_Home/ssact/title19/1927.htm](http://www.ssa.gov/OP_Home/ssact/title19/1927.htm)

<sup>40</sup> An example of this can be found at [ftp://ftp.hrsa.gov/bphc/pdf/chc/nfa\\_worksheet.pdf](ftp://ftp.hrsa.gov/bphc/pdf/chc/nfa_worksheet.pdf)

<sup>41</sup> CMS generally considers primary care services to mean routine health care services, including screening, assessment, diagnosis, and treatment for the purpose of promotion of health, and detection and management of disease or injury. *CMS Proposed HIE Rule* Page 41900

Washington [state]<sup>42</sup>. CMS considered allowing an individual to purchase a PCMH plan and separately acquire wrap-around coverage, but PCMHs are providers and not insurance companies. Additionally, CMS was concerned with the potential necessity of requiring a second payment by enrollees for this additional medical coverage.

However, the rule's text also proposes to allow QHPs to develop such plans, with the requirement of developing standards and measurements. By so doing, this would negate the necessity by enrollees to provide for an extra payment. In other words, if QHPs developed PCMH standards (or contracted/adopted a current certification process – such as the [National Committee for Quality Assurance](#)<sup>43</sup>) and applied them to their own payment [to providers] structure, there would be no need to require enrollees to pay an additional premium, as the additional cost<sup>44</sup> could be included within the premium costs.

## II. Conclusion

The most prevalent concerns and issues raised in this letter are that FQHCs and their patients afforded the same opportunities under the proposed HIE system as any other provider(s) or patients. Providing for the nation's most vulnerable citizens and maintaining the safety net are two of the most imperative ambitions put forth through the Affordable Care Act and the intent of this CMS rule.

CMS has included specific language to address FQHCs as part of the Exchange structure. However, FQHCs are not alluded to within the rule's proposals to be a required provider – which may be a mistake and a detriment to the success of the HIE program(s). Based on the track record of FQHCs, as acknowledged by CMS, bringing FQHCs and their patients into the HIE will result in lower expenditures and greater access to affordable care.

FACHC has recommended payment rule language to be considered as a negotiable middle-point, wherein all stakeholders and interested parties would be provided a common ground, from which all would be satisfied and an agreement could be reached. It is in the best interests of CMS and the federal government to allow as much autonomy as possible to the Exchanges, the QHP issuers, the providers and the consumers, as free-market principles would suggest that the most affordable, best-fitting services would be sought and acquired, in the process, streamlining and reducing costs to all involved.

FACHC has also provided comments on the Small business Health Option Programs (SHOPs). As a small business itself – and an organization representing 45 other small businesses – FACHC has been provided the unique perspective through which we can make suggestions that will be the most encompassing and, yet, most specific. FACHC boasts an employee base of 11 – well under the cap of 50 – but represents Federally Qualified Health Centers, whose employee bases range from only a handful to hundreds. In all instances, the individual locations are relatively independent of one another and should be construed as small businesses. It is with this mindset that FACHC has suggested a number of adjustments to the proposals laid forth by CMS in this rule.

In the fourth section of this response, FACHC responded to a number of requests for comment by CMS that would not, necessarily fall comfortably under the first two categories. These provisions, however are important to both FACHC and its members and require the attention of CMS. There is not an expectation that CMS will accept the recommendations proposed by FACHC, however, CMS is encouraged to thoroughly absorb the contents and meanings behind the suggestions and utilize the intentions behind the words in authoring the finalized version of this rule and the Affordable Care Act's implementing language.

To put in place too much regulation would be a mistake; but to neglect putting in place enough would be equally catastrophic.

Thank you for the opportunity to comment on CMS' proposed rule(s) on the Patient Protection and Affordable Care Act's Establishment of Health Insurance Exchanges and Qualified Health Plans

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<sup>42</sup> The direct primary care medical home model in the State of Washington has benefited providers by providing predictable income without added administrative costs, while consumers gain access to an affordable and reliable source of primary services that decreases reliance on emergency rooms as a source of routine care. *CMS Proposed HIE Rule* Page 41900

<sup>43</sup> <http://www.ncqa.org>

<sup>44</sup> Some additional costs may not be a relevant point in the HIE, such as the role of Navigators – paid for by a different source – which would be responsible for patient/QHP enrollment activities. However, other costs, such as care coordination/coordinators, would produce a separate, potentially additional cost. Administrative/overhead expenses such as these are often paid to the provider in the PCMH model through a per member per month amount (which reimburses a practitioner for each patient on a monthly basis, regardless of care coordination or provision, as an incentive to reduce long-term costs and improve short and long-term health outcomes).

If you wish to contact FACHC with any questions or comments:

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