AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

September 28, 2011

Donald Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS–9989–P
Mail Stop: C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: Establishment of Exchanges and Qualified Health Plans

Dear Dr. Berwick:

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 100,300 family physicians and medical students nationwide, I write in response to the Centers for Medicare & Medicaid Services' (CMS) proposed *Establishment of Exchanges and Qualified Health Plans* as published in the July 15, 2011 *Federal Register*.

State health insurance exchanges (exchanges) are organizations that will facilitate the purchase of health insurance coverage in the individual and small group markets. States will have the flexibility to establish a statewide exchange, regional exchanges or multi-state exchanges, provided each state party to an exchange passes statutes accepting the arrangement. States may choose to operate separate exchanges for the individual and small group markets, or merge the two markets into a single exchange. The proposed rule lays out the initial guidelines the US Department of Health & Human Services (HHS) will consider before signing-off on the ability of state exchanges to begin offering coverage on January 1, 2014. If a state is unprepared to meet this deadline, the *Affordable Care Act* (ACA) allows HHS to operate the exchange on behalf of the state's citizens. We look forward to further guidance on how HHS will implement this provision.

Since the AAFP continues to support efforts to improve patient access to affordable health insurance coverage, we were pleased that the *ACA* included Section 1311, which outlines the general responsibilities and goals of the exchanges, and Section 1321, which discusses the flexibilities granted to states in establishing and operating the exchanges. To ensure exchanges utilize all primary care has to offer, the AAFP developed the Family Medicine Principles for State Health Insurance Exchanges. As HHS reviews comments submitted to this proposed regulation and as the department prepares the final regulation on exchanges, we encourage HHS to consult and adhere to these recommendations as closely as possible.

Structure of Exchanges
Much of the proposal regarding the structure of state health insurance exchanges follows closely the model provided in the *ACA* thus HHS had little regulatory room to deviate from the statute. Nevertheless, the AAFP

commits to working closely with states as they make determinations whether or not it will create an exchange. If a state opts not to operate an exchange, we likewise commit to working with HHS to properly establish and operate the exchange in that state. HHS invites comment on operational and policy concerns regarding the possibility of allowing subsidiary exchanges that cross state lines. This would be a hybrid of regional and subsidiary exchanges designed to serve a population clustered around state borders. Such an exchange would present significant technical challenges for states, issuers and providers. If HHS chooses to pursue this latter option, AAFP would encourage caution and further rulemaking outlining a clear, methodical approach for approval.

The *ACA* requires each exchange to be approved by HHS by January 1, 2013 and for exchanges to be operational on January 1, 2014. The rule proposes that the approval process will require each state to submit a plan detailing how the exchange is prepared to operate according to the standards set forth in a final rule. HHS will draft a template outlining the required components of an Exchange Plan. The AAFP looks forward to reviewing and commenting on this template to ensure it properly emphasizes the role of primary care physicians and the value of preventive and primary care. Research has consistently demonstrated that increased prevalence of primary care physicians effectively improves health outcomes. The AAFP believes that implementation of the patient-centered medical home is the model that best meets the goals of improving the quality of care and helping to restrain health care costs. This comprehensive model provides not only the first contact a patient has with the healthcare system, but also the preventive care, management of chronic conditions and coordination of services provided by all the other members of a patient's healthcare team. HHS regulations and the exchanges should work with the medical community to utilize the patient-centered medical home in order to reward prevention and wellness, eliminate fragmentation and duplication, and produce a cohesive system of care that prevents unnecessary complications from acute or chronic illness, hospitalizations, and other avoidable expenses.

As states may wish to modify their exchanges in the future, HHS is considering using the State Plan Amendment process currently in place for the Medicaid program and Children's Health Insurance Program (CHIP). This process requires that states notify and receive approval from HHS prior to implementing "significant changes" to an exchange. The term "significant change" has been, at times, problematic in Medicaid and the AAFP believes further guidance is warranted. While the AAFP appreciates flexibility for states, some states do not currently undertake robust access reviews and will likely require assistance both in submitting modification requests and understanding responses from HHS. The AAFP urges HHS to issue further guidance clearly defining "significant change" and to include a strong enforcement mechanism to ensure exchange compliance with HHS rules.

Governance

HHS proposes that governing boards for exchanges must, in addition to several other requirements, not have a majority of voting members representing health insurers, agents or brokers. HHS also proposes a majority of voting members with "relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets." The AAFP concurs with these proposals but the proposed rule does not require governing boards to include voting membership specifically reserved for patients and primary care physicians. The AAFP's "Family Medicine Principles for State Health Insurance Exchanges" encourages exchange governing boards to require at least one seat for consumers and at least one for primary care physicians, in at least equal proportion to the total number of seats allotted to insurers, specialty medicine, health systems and other stakeholders. We therefore urge that HHS, in the final rule, include this additional requirement to ensure that exchanges are primary care driven.

Physicians should not be among the entities that are identified as having a potential conflict of interest. The intent of the conflict of interest standard is to ensure that the membership of the governing board appropriately represents consumer interests. Unless a physician is directly affiliated with or represents a

particular health plan, the physician would not pose a conflict of interest and would offer a unique and important perspective to exchange governance.

Accreditation of Insurers
Exchanges are required to accredit insurers wishing to offer qualified health plans (QHP). QHP issuers must be accredited based upon local performance of its QHPs by an entity recognized by HHS. HHS does not suggest any specific entities and seeks comment on the standards by which HHS should recognize accrediting bodies; the agency may wish to use or adapt the process employed by HHS for Medicare Advantage plans as a model. The *ACA* lists nine criteria that must be used in the accreditation process:

- Clinical quality measures, such as the Healthcare Effectiveness Data and Information Set;
- Patient experience ratings on a standardized CAHPS survey;
- Consumer access;
- Utilization management;
- Quality assurance;
- Provider credentialing;
- Complaints and appeals;
- Network adequacy and access; and
- Patient information programs.

Quality measures should be aligned across plans in exchanges and with the state's Medicaid, CHIP and state and local employee health benefits plans. Such measures also should coordinate with Medicare, when possible. Reporting to multiple payers on different measures creates an undue administrative burden on physician practices. The *ACA* encourages exchange plans to create market incentives for quality improvement to coordinate care and reduce the use of unnecessary care. If exchanges require physicians and plans to spend significant resources on initiatives not required of non-exchange plans, exchange plans could seem less competitive and increase the already substantial reporting burden on physicians.

Supplementing these criteria, AAFP suggests the inclusion of standard physician contracts. Physician contracting should be standardized across all plans in any exchanges, just as enrollee applications are standardized. States opting to create multi-state exchanges, or enter into interstate compacts for the purchase of insurance, should harmonize contracting rules across all participating states. "All products clauses" must be prohibited. With a large influx of patients, network adequacy standards will require issuers of QHPs to develop and maintain robust provider networks. HHS, states and issuers should take advantage of the opportunity to rationalize physician-insurer contracting to ensure access for newly covered patients.

The AAFP urges CMS to forbid exchanges from developing localized coding and billing rules. Physician practices should not be subjected to a patchwork array of local coverage determinations or geographically specific coding rules. Exchanges must adhere to standardized coding, billing, and documentation standards.

We strongly urge HHS to consider encouraging exchanges to set primary care medical spending targets for issuers offering QHPs on exchanges. As demonstrated in numerous studies, investments in high-performing primary care, such as the patient-centered medical home, offer great return. The AAFP encourages HHS and states to pursue further support of the patient-centered medical home and primary care in exchanges.

Enrollment in Qualified Health Plans
Enrollees should receive presumptive eligibility—or provisional enrollment—to allow for delivery of essential preventive and primary care services upon submission of an application. Not only do disruptions in insurance coverage have adverse effects on access to care and administrative costs, problems can arise simply from changes in health plans, even without gaps in coverage. The *ACA* expands presumptive eligibility for Medicaid applicants and first-dollar coverage of preventive services. Combining presumptive

eligibility for all plans, public and private, with the new first-dollar coverage for preventive services delivered by primary care physicians will help keep patients out of emergency rooms while controlling costs. The AAFP encourages HHS through this or future rulemaking to simplify patients' transitions between plans through policies that reduce administrative burdens, such as portability of prescriptions and prior authorizations.

Open enrollment, special enrollment and disenrollment procedures should minimize gaps in coverage and avoid disruptions in access to a patient's medical home or usual source of care. Given the large numbers of patients to be enrolled and the potential for confusion about options and requirements under the individual mandate, it is recommended that the initial enrollment period be longer than the proposed five-month period. Additionally, coverage effective dates should be expedited to avoid gaps in coverage and disruptions in access to care. In particular:

- A delay of up to five weeks following enrollment before coverage starts is not acceptable, particularly given the advanced state of technology to be used in managing eligibility and enrollment. A coverage gap is not optimal for any patient population.
- To avoid imposing additional financial costs on families, reasonable notice for families wishing to disenroll from a plan should be 24 hours in a real-time environment.
- Generally speaking, triggering events are not associated with changes in health status, thus the prohibition against movement among levels of coverage is unnecessary to avoid adverse selection.

For special enrollment periods, the rule proposes limiting an existing enrollee of a QHP to only changing plans within levels of coverage. HHS recognizes that limiting enrollees to a specific level would pose a challenge for an enrollee in a catastrophic plan who becomes pregnant. The AAFP fully supports a women's ability to change plans, should she become pregnant while enrolled in a catastrophic plan. Additionally, the AAFP requests that pregnancy be made an exceptional circumstance which would trigger a special enrollment period, so that a woman enrolled in a catastrophic plan is able to gain coverage that offers maternity care.

Network Adequacy

The AAFP is concerned that HHS's proposal leaves determination of network adequacy, in large part, to the states or exchanges. For the exchanges to work properly, essential community providers including primary care physicians must be included in the network. The AAFP urges HHS, in the final rule, to specify that exchanges must abide by network adequacy standards and make their provider directory available online to applicants and enrollees. The rule proposes that a qualified health plan operating in the exchange must include a "sufficient number" of essential community providers in its network. HHS, in its discussion of network adequacy, notes recognition of the *ACA's* focus on primary care, as well as the challenge of the primary care physician workforce crisis. However, HHS's encouragement of states, exchanges and insurers to, "consider broadly defining the types of providers that furnish primary care services (e.g., nurse practitioners)," is a potential concern to the AAFP and primary care medicine. The AAFP urges exchanges to emphasize services from properly trained, physician-led primary care teams, which are best suited to practice efficiently, effectively, and in a comprehensive way for their patients.

Direct Primary Care Medical Homes

The *ACA* permits qualified health plans operating in an exchange to offer coverage through a "qualified direct primary care medical home plan." HHS provides little guidance on this provision in the proposed regulation, except stating that the qualified health plan meets all requirements that are otherwise applicable and the services covered are coordinated with the qualified health plan issuer. In the proposed regulation, HHS notes that it interprets the phrase "direct primary care medical home" 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. HHS notes it based its interpretation on a model operating in Washington State. HHS generally considers primary care services to be routine health services, including screening, assessment, diagnosis

and treatment for the promotion of health, and detection and management of disease or injury. HHS considered, but declined, to allow through the proposal that individuals could purchase a direct primary care medical home plan and separately acquire wrap-around coverage. This consideration was rejected as administratively burdensome and that it would require exchanges to accredit or certify providers as direct care primary care medical homes. HHS specifically requests comment on what standards HHS should establish under this section of the rule.

The AAFP recommends that HHS adopt or incorporate standards and criteria already developed, such as those listed in Guidelines for Patient-Centered Medical Home (PCMH) Recognition and Accreditation Programs, issued in March 2011 (§156.245). Those guidelines build on the *Joint Principles of the Patient-Centered Medical Home*, developed and adopted in February 2007 by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association, and since endorsed by other physician associations. The guidelines describe elements considered essential for effective PCMH recognition programs, and state that programs should attempt to assess all of the primary care domains outlined by the Institute of Medicine—comprehensiveness, coordination, continuity, accessibility, and patient engagement and experience.

Non-Renewal and Decertification of QHPs
HHS proposes that QHP issuers that wish to discontinue a QHP in the exchange must notify the exchange prior to the beginning of the QHP's recertification process. Additionally, the QHP must fulfill its obligation to cover benefits for each enrollee through the end of the benefit or plan year, whichever is applicable; fulfill data reporting obligations from the last plan or benefit year; provide written notice to enrollees; and, follow the exchanges coverage termination guidelines. HHS proposes that if a QHP is decertified by the exchange, it may not terminate coverage until enrollees have been notified and received an opportunity to enroll in other coverage. The proposed rule is silent, though, on the issuance of notifications of non-renewal or decertification to participating providers. The AAFP encourages HHS to consider adding notification of providers of the non-renewal or decertification of issuers and health plans to the final rule.

We appreciate the opportunity to provide these comments and make ourselves available for any questions you might have or clarifications you might need. Please contact Greg Martin, State Government Relations Manager, at 202-232-9033 or gmartin@aafp.org.

Sincerely,

Roland A. Goertz, MD, MBA, FAAFP
Board Chair