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Responses to California Health Benefit Exchange Stakeholder Questions: Developing Options for the Exchange - Qualified Health Plans, Benefit Design, and Promoting Delivery System Reform

Prepared by the National Health Law Program for the California Coalition for Reproductive Freedom members:

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1. What minimum standards for qualified health plans in the Exchange would ensure a basic level of service, access, consumer protection and health care quality?

The state of California has developed extensive rules governing health plans through the Knox-Keene Act. At a minimum, the Exchange should allow only Knox-Keene licensed plans to participate in the Exchange as QHPs to ensure that all enrollees have access to the consumer protection provisions of the Knox-Keene Act. By requiring QHPs to be Knox-Keene licensed, the Exchange will ensure that QHP enrollees have access to the consumer remedies available through the Department of Managed Health Care in addition to exercising their grievance rights through the Exchange or the QHPs themselves. In the alternative, if the Exchange decides to permit plans that are not Knox-Keene-licensed to become certified as QHPs, the Exchange must require, through the contracting process, those plans to provide Knox-Keene protections to enrollees. While the Knox-Keene protections and accompanying regulations are neither specifically designed for nor adequate to address the needs of those who will enroll in QHPs through the Exchange, they offer a minimal baseline of enforceable protection for enrollees. Our additional recommendations follow:

- ***Minimum standards to ensure access to a sufficient level of service***

Newly promulgated regulations at 45 C.F.R. §§ 156.230 and 155.1050 establish minimum standards to ensure that QHPs' networks provide adequate access to necessary services. We urge the Exchange to adopt additional, specific standards beyond this federal floor to assure that enrollees have full access to the range of services needed.

- **The Exchange should establish a metric for determining the number and types of providers needed to ensure that enrollees have access to all services.**

To ensure access to services, the Exchange should develop criteria to measure the number of providers that account for variation in specialty type and geography, similar to those used in the Medicare Advantage program. After enrollment commences, the Exchange should update the criteria based on utilization patterns and clinical needs. Such criteria fulfill the goal of assuring that enrollees have access to services, while incorporating flexibility to account for local variation. We recommend that such criteria be developed using the 2011, 2012, and 2013 Medicare Advantage Network Adequacy Criteria as a model (*see, e.g.,* Centers for Medicare & Medicaid Services, *2011 Medicare Advantage Network Adequacy Criteria Development Overview*, https://www.cms.gov/MedicareAdvantageApps/Downloads/2011_MA_Network_Adequacy_Criteria_Overview.pdf). In addition, we suggest that the Exchange refer to the provider ratio criteria contained in the Department of Managed Health Care's regulations at 28 C.C.R. § 1300.51(H).

The Exchange's criteria should account for the needs of special populations who will be purchasing health insurance through the Exchange. These populations include children, people with disabilities, limited English proficient enrollees and women of reproductive age. In addition to the usual range of providers and the Essential Community Providers described below, QHPs must be required to offer access to the following providers and services in their networks: interpreters, inpatient and outpatient rehabilitative programs, comprehensive rehabilitative and habilitative services, applied rehabilitative technology programs, wheelchair seating clinics (including access to wheelchair assessments) independent of durable medical equipment providers, specialty care centers (including those Ryan White Care providers serving people living with HIV), Genetically Handicapped Persons Program certified providers, non-coercive reproductive health services, speech pathologists (including those experienced working with nonverbal individuals, persons with developmental disabilities, and persons who need speech generating devices), occupational therapists, orthotics providers and fabricators, physical therapists, case managers for those with significant non-medical barriers to care, Applied Behavioral Analysis (ABA) therapy, and low vision centers. To achieve this goal, we urge the Exchanges to work with the Legislature and other relevant state agencies to define broadly the kinds of providers that can furnish primary care services. Finally, the Exchange should require QHPs to certify that their providers' facilities are accessible to all enrollees, and fully compliant with the Americans with Disabilities Act (ADA) and other state and federal disability and civil rights laws.

In addition, in many rural areas of the state, managed care networks do not exist and safety net providers are often the only source of health care for the community. The Exchange should develop robust criteria to ensure that enrollees in those regions have access to comprehensive, geographically representative networks of providers. Moreover, the Exchange should impose transparency standards to evaluate the primary care capacity of health plan networks in every

region by assessing metrics such as the ratio of primary care providers to population and other measures of capacity.

As discussed above, the goal of developing specific metrics to measure the number of providers in a network is to ensure that enrollees have meaningful access to the health care services they need. Thus, such metrics must account for the range of services offered by participating providers, and whether providers are accepting new patients. If an enrollee needs contraception or abortion services, for example, but her plan only offers OB/GYNs who perform pelvic exams and provide prenatal care, the services she needs are not actually accessible to her. Similarly, if an enrollee needs primary care, but his plan does not offer any primary care providers who are accepting new patients, the services he needs are not actually accessible to him. For this reason, as described in greater detail below, the Exchange should require QHPs to contract with essential community providers for the full range of services they offer, rather than only contracting for limited subsets of service. Further, the Exchange should require QHPs to report specifically on which providers are accepting new patients to ensure that new enrollees have access to the providers they need.

Recommended standard (adapted from 42 C.F.R. § 422.112):

> *Each QHP issuer shall maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. Each QHP that is certified to participate in the Exchange must meet the following requirements:*
>
> *(1) The QHP shall meet or exceed the standards established by the Exchange for the number of providers in its provider network that account for the services offered by the providers in its network, and the proportion of providers in its network that are accepting new patients.*
>
> *(2) The QHP shall establish written standards for its providers that ensure that provider facilities are accessible to people with disabilities and compliant with the Americans with Disabilities Act and other state and federal disability and civil rights laws.*

- **The Exchange should ensure that its standards provide access to the full scope of services.**

The Exchange must require QHP issuers to ensure that ***all*** essential health benefits are covered in ***each*** QHP that is certified to participate in the Exchange. There should be no question that a consumer will have meaningful access to the full range of covered services regardless of the plan into which he or she enrolls. The Exchange must also contract with QHPs that cover comprehensive reproductive health services, including abortion services; every enrollee should have the option of enrolling in a QHP that covers abortion services. In addition, the Exchange should set minimum standards to ensure that there are sufficient types of providers or provider networks, including specialists, who actually provide all covered services. A standard that merely counts the numbers and types of providers is not sufficient. For example, ensuring the actual provision of services is especially important for women who may need covered reproductive health services, if some or all of the providers in the area do not provide those

services. Such minimum standards should take into consideration the fact that some hospitals and clinics, particularly religiously controlled ones, may not provide all of the covered services, and individual providers may refuse or be unable to offer covered services. These restrictions may limit access to comprehensive reproductive health services and information, as well as end of life care, transgender care, and information about treatment options. Moreover, in the event that an enrollee is not able to access covered services or a necessary provider within the existing covered network (for example, due to provider religious or moral objections), the QHP must be required to allow the enrollee to access services out-of-network without penalty, including in the case of emergencies, without additional cost to the enrollee. QHPs must be required to establish payment mechanisms for out-of-network care that ensure that enrollees are not subjected to additional cost-sharing when they must access covered services out-of-network.

As to reproductive services, the Exchange must require QHPs to inform enrollees if they do not cover those particular services in their Summary of Benefits and Coverage Explanation. If abortion services, including hospital-based abortions are not available from providers in the network, QHPs must maintain a process and criteria for timely evaluation of access to out-of-network providers to obtain covered services without penalty or additional cost to the patient. Among other things, if a QHP contracts with institutions or individual providers who refuse to provide a full range of reproductive health services, QHPs must also:

- contract with at least one institutional provider and one professional provider within the same geographic area that provides covered services in-network providers refuse to provide;
- If there is no provider in the geographic area that offers the covered services, contract with additional providers in nearby regions;
- ensure a protocol is in place to allow enrollees to obtain covered services when a primary care provider refuses or is unable to make a referral to needed services; and
- inform consumers during the plan selection process of any restrictions to reproductive health services imposed by health entities in their network including compliance with AB 525 (codified at Health & Safety Code § 1363.02, Insurance Code § 10604.1, and Welfare and Institutions Code § 14016.8).

Recommended standard:

Each QHP issuer shall maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. Each QHP that is certified to participate in the Exchange must meet the following requirements:

(3) The QHP shall meet or exceed the standards established by the Exchange for the number of providers in its provider network that account for the services offered by the providers in its network, and the proportion of providers in its network that are accepting new patients.

(4) The QHP shall establish written standards for its providers that ensure that provider facilities are accessible to people with disabilities and compliant with

the Americans with Disabilities Act and other state and federal disability and civil rights laws.

- **The Exchange should establish time and distance standards to ensure that providers are located reasonably proximate to enrollees.**

We urge the Exchange to establish specific standards under which QHP issuers would be required to maintain arrangements that ensure a reasonable proximity of participating providers to the residences or workplaces of enrollees. We suggest that, at a minimum, the Exchange require QHPs to meet the geographic standards for primary care and hospital access contained in the Department of Managed Health Care's regulations at 28 C.C.R. § 1300.51(H).

These criteria should be regularly monitored to ensure that enrollees have meaningful access to the health care services they need. The Exchange should develop criteria to evaluate appropriate travel time and distance that account for variation in specialty type and geography. After enrollment commences, the Exchange should update the criteria based on the locations of enrollees' homes and workplaces.

Recommended standard:

(1) All enrollees have a contracting or plan-operated primary care provider within 30 minutes or 15 miles of their residence or workplace.

(2) All enrollees have a contracting or plan-operated hospital which has a capacity to serve the entire dependent enrollee population based on normal utilization, and, if separate from such hospital, a contracting or plan-operated provider of all emergency health care services within 30 minutes or 15 miles of their residence or workplace .

- **The Exchange should establish minimum timely access standards to ensure that services are available in a timely manner.**

Finally, the Exchange should establish specific standards under which QHP issuers would be required to ensure that services are accessible without unreasonable delay. We suggest that the Exchange adopt the Department of Managed Health Care's clear timely access standards for primary care, mental health, urgent care, specialty care, and ancillary care appointments, found at 28 C.C.R. § 1300.67.2.2(c)(5). In addition, the Exchange should affirm that emergency care must be available to Exchange plan enrollees 24 hours a day, 7 days per week, as required by 28 C.C.R. § 1300.67.2(c). The Exchanges must evaluate QHPs to ensure that they meet those standards.

Recommended Standard:

(1) Emergency health care services shall be available and accessible twenty-four hours a day, seven days a week;

(2) Urgent care appointments for services that do not require prior authorization shall be available and accessible within 48 hours of the request for appointment

(3) *Urgent care appointments for services that require prior authorization shall be available and accessible within 96 hours of the request for appointment*
(4) *Non-urgent appointments for primary care shall be available and accessible within ten business days of the request for appointment;*
(5) *Non-urgent appointments with specialist physicians shall be available and accessible within fifteen business days of the request for appointment;*
(6) *Non-urgent appointments with a non-physician mental health care provider shall be available and accessible within ten business days of the request for appointment;*
(7) *Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition shall be available and accessible within fifteen business days of the request for appointment.*

- **Minimum standards to ensure a basic level of consumer protection.**

    - **The Exchange should establish minimum standards for QHP's grievance and appeal procedures to protect enrollees' due process rights.**

Section 2719 of the Public Health Services Act, and the regulations and guidance interpreting that section, set out rules for plans' internal and external appeals processes of adverse benefits determinations. These rules will apply to QHPs operating in the Exchange. We urge the Exchange to adopt and monitor robust guidelines to ensure that QHPs employ adequate grievance and appeal procedures when a QHP or its utilization review organization (including IPAs) makes an adverse benefits determination regarding an admission, availability of care, continued stay, or other health care service that does not meet applicable standards for medical necessity, appropriateness, health care setting, level of care or effectiveness, or a denial, termination or reduction of a requested service or payment for the service. These procedures must include a process for expedited grievances and appeals in urgent situations. In addition, the Exchange should require QHPs to have a process for independent medical review of decisions that deny, modify, or delay health care services, that deny reimbursement for urgent or emergency services, or that involve experimental or investigational therapies. In developing grievance and appeal guidelines for QHPs, we recommend that the Exchange require, to the extent consistent with Federal guidelines, compliance with Cal. Health & Safety Code § 1368(a) and the Department of Managed Health Care's grievance and appeals procedures at 28 C.C.R. Art. 8. Finally, we urge the Exchange to require QHPs to track the grievances and appeals filed, and regularly disseminate that information broadly, including online.

Further, the Exchange should take special care to ensure that QHP grievance and appeals procedures protect the rights of vulnerable enrollees, including children, people with disabilities, limited English proficient enrollees and women of reproductive age. In particular, the Exchange should require QHPs to issue all written materials, including notices of denials, reductions or terminations of service, in a manner that accessible to limited English speakers and persons with disabilities, as described in greater detail below in our response to question 5(b).

- **The Exchange should establish standards to safeguards enrollees' confidentiality.**

The Exchange must ensure that there are strong security safeguards to ensure the privacy and security of personally identifiable information and follow existing Health Insurance Portability and Accountability Act (HIPAA) laws when transferring eligibility, enrollment and disenrollment information between health insurance programs, health plans, etc. We recommend that all application assistors, private vendors administering the system, and entities conducting screening prior to an individual's submission of an application or request for renewal abide by these privacy laws in order to protect the confidentiality of applicants and participants. Applicants should also be informed up-front about their privacy rights.

The Exchange should also require that each QHP establishes and maintains systems to protect the confidentiality of sensitive reproductive health services for adolescents and adults.

- **In general: The Exchange should establish a regular and transparent process to collect and evaluate data to assess whether QHPs are meeting its standards**

We urge the Exchange to establish methods to assess proposed QHPs in the certification process that measure their compliance with its established minimum standards for service, access, consumer protection and health care quality. The newly promulgated regulations at 45 C.F.R. §§ 155.1000(c) and 155.1075 establish minimum guidelines for the certification and recertification process, respectively, but allow the Exchange to establish its own standards above and beyond the federal floor. At certification, plans must either demonstrate that they are already in compliance with the Exchange's standards or have a clear plan for coming into compliance by the date that enrollees will begin coverage.

We also recommend that the Exchange require QHP issuers to maintain an ongoing monitoring process to ensure that they are meeting the Exchange's minimum standards. This monitoring process should pay special attention to measuring how well each QHP is meeting the needs of vulnerable populations served by the Exchange, including children, people with disabilities, limited English proficient enrollees and women of reproductive age. The Exchange must require QHP issuers to demonstrate adherence to its established standards in an ongoing way in order to continue participating in the Exchange. While the recertification process will give the Exchange the opportunity to review QHP issuers' compliance with its standards, the Exchange should require the QHP issuers to monitor compliance more frequently, especially in the first five years of the Exchange, since most problems occur in the early years of a new system. The Exchange should require the QHP issuers to establish a written process for monitoring their QHPs with respect to each of its minimum standards on a regular basis; take corrective action if a QHP falls out of compliance; and report such corrective action to the Exchange. In addition, the Exchanges should require QHP issuers to report any material changes in their QHP provider networks, confidentiality procedures, and grievance and appeals policies to the Exchanges within 30 days.

Further, the monitoring process used must be transparent, publicly available, and easy for consumers to understand. While the federal regulations at 45 C.F.R. § 156.220 will establish certain data points that must be made publicly available by QHPs, we urge the Exchange to go further and require that all non-confidential information derived through the monitoring process be broadly disseminated. This data must be accessible online and in written form so that consumers can be made aware of any problems, as well as compare and contrast plan performance. And, like all information provided in connection with the Exchange, this information should be conveyed in a manner that is easily understood and accessible to people with low literacy, limited English proficiency, and disabilities.

4. What strategies and approaches should the Exchange consider, and what existing standards in areas such as level of service, consumer protection and quality measurement can it incorporate, in order to develop a timely and streamlined process for certification and selection of carriers and qualified health plans?

When selecting health plans and launching the operations of the Exchange, there should be extreme sensitivity to the transition of applicants/enrollees who are under care from their current providers or health plans to a health plan under the Exchange. There may be a substantial number of persons who are currently enrolled in Low Income Health Plans (LIHPs), which can serve individuals with incomes up to 200% FPL who will be transitioning to Exchange health plans. Special attention should be paid to them and to the elderly, disabled and other vulnerable populations as this transition occurs. The Exchange should focus on lessons learned from the recent, sometime rocky, transition of Seniors and Persons With Disabilities from Fee-for-Service Medi-Cal into mandatory managed care. Where possible, the Exchange should look to include health plans that are already serving these populations, so that no transition of providers will be necessary. To the extent that is not possible in certain geographic areas, there must be a carefully thought-out process for transition to new providers and sharing of medical records for those currently undergoing care for ongoing complex and chronic conditions.

When selecting health plans, the Exchange should strive to contract with health plans that cover comprehensive reproductive health services, including abortion services. Further, the Exchange should ensure that every enrollee, irrespective of geographic location, has the option of choosing a health plan that covers abortion services.

5. What criteria should be considered a priority for the Exchange in certifying and selecting qualified health plans that might either reference or exceed regulatory minimums, including but not be limited to:

a. Evidence of consumer-focused and consumer-friendly coverage and services;

To ensure that plans provide consumer-focused coverage, we suggest that the Exchange give priority to health plans that have established a model for patient centered medical homes (PCMHs). The Affordable Care Act emphasizes the importance of PCMHs. A PCMH is a health care setting that facilitates partnerships between individual patients, and their personal

physicians, and when appropriate, the patient's family. In 2011, the National Committee on Quality Assurance (NCQA) (http://www.ncqa.org/tabid/631/default.aspx), and the Accreditation Association for Ambulatory Health Care (AAAHC) (https://application.aaahc.org/MedicalHome.aspx) established model standards and guidelines for certifying PCMHs that could be adapted by the Exchange to assess whether QHPs are able to provide patient-centered, coordinated and effective care to their enrollees, especially those with complex health care needs or multiple chronic conditions. Plans that contract with providers that have been recognized by the NCQA or AAAHC as meeting their PCMH guidelines should be given priority in the QHP selection process.

The Exchange will serve consumers with a range of needs and secondary conditions that are not well served by a "one-size-fits-all" approach to health care delivery. In order to ensure that QHPs are able to meet the needs of people with various health care conditions, the Exchange should strive to contract with QHPs offering a range of delivery models. Numerous health care delivery models exist across the nation. Disability Care Coordination Organizations combine attributes of the medical home model and community nursing, and the client works with teams of nurses and social workers to arrange disability-competent medical and social services. AXIS Healthcare in Minnesota is one example of this model in action. The Targeted Disease Management Model focuses on individuals who have a specific secondary condition and combines self-management interventions with clinical monitoring to improve patient health outcomes. The Care Transitions Model focuses on an individual's transition between one health care setting or level of health care to another and is designed to ensure coordination and continuity of care as these transfers occur through the use of interdisciplinary teams, targeted technology, and home-based clinical monitoring. Intensive Multidisciplinary Team models coordinate medical and behavioral health care and link enrollees to community agencies and organizations to meet the needs of enrollees with complex social barriers to care. The Washington State/King County Medical Home and Chronic Care Management Programs and the New York Chronic Care Initiative are examples of this model. The Disability Health Coalition (DHC), www.disabilityhealthcoalition.org, has additional information on these and other models.

b. Assuring culturally and linguistically appropriate services and providers;

Because of the large numbers of limited English proficient (LEP) individuals who will be purchasing insurance through the Exchange, it is absolutely critical that the Exchange assure that linguistically appropriate services are provided by the health plans that are certified for inclusion in the Exchange. If the Exchange is going to meet its admirable goal of "improving the health of all Californians by assuring their access to affordable and high quality care," the exchange must assure that LEP individuals, as well as other cultural and sexual minorities, receive care in a manner that fully meets their needs and assures effective communication between them and their providers and their health plan.

While health plans included in the Exchange will have to comply with the requirements of Title VI of the Civil Rights Act of 1964, Section 1557 of the ACA (non-discrimination) and Health and Safety Code Section 1367.04 (SB 853), the Exchange should go further and require that the

plans translate all vital documents, including enrollment forms and notices of action, into the Medi-Cal Managed Care Threshold languages. We also urge the Exchange to require plans to comply with Department of Managed Health Care standards on language access and cultural competence and to impose additional transparency standards to evaluate cultural and linguistic access for newly insured populations. The Exchange has already recognized the importance and relevance of these guidelines by referencing them in the requirements set forth in the RFP for CalHEERS Development and Services. Tag lines in at least 15 languages should also be required on all notices sent to enrollees. The Plans should be required to demonstrate that they are using competent translators to translate their plan documents, notices and material on websites. The Exchange should require that Plans use translators certified by the American Translators Association, or, at a minimum, require that Plans demonstrate that their translators meet minimum standards of competence in some other way. Plans should also be required to have notices written at a low literacy level so that comprehension is ensured and the provision of information is not merely pro forma but offers a real opportunity for enrollees to understand the information.

All plans must be required to have oral interpretation services available for their enrollees in all languages on a 24-hour basis, at no cost to the enrollee. Further, there must be assurance that the interpretation services that are provided meet a satisfactory level of competence. There are a number of ways to ensure competence, many of which are detailed in HHS's LEP Guidance. As one example, national competency assessments could be required, such as healthcare certification (available in Spanish, Arabic and Mandarin) or credentialing (available in all other languages). The plans should be required to demonstrate to the Exchange how they will provide competent interpretation services for enrollees who speak languages other than the Threshold languages. In addition to issues regarding enrollment, provider assignment and service delivery, the oral interpretation services should be made available for any appeal processes conducted by the plans. Enrollees should NEVER be required to rely on family members or friends for interpretation.

The requirement of oral interpretation services must apply both to the plans themselves in their communications with their enrollees, and for interactions between the enrollees and the providers (including IPAs) contracted with the plans. As part of the contracting requirements, health plans should be required to pay for such services for their contracted providers. This will ensure the availability of language services and improve compliance by providers who often do not have the resources to evaluate or pay for competent language services. Enrollees who need oral interpretation assistance should not be disadvantaged by having to endure any significant waiting time for such assistance. The Exchange should adopt timeliness standards for the provision of such assistance.

Before being certified for participation in the Exchange, plans should be required to set forth in detail their process for paying for and guaranteeing timely oral interpretation services, both for their own customer service functions and whenever it becomes necessary to facilitate communication between enrollees and providers. These language access plans should be made available to the public.

In addition to the provision of translated documents and interpretation services, cultural sensitivity in the provision of services is vitally important. Plans should be required to demonstrate how they intend to assure that their network of providers will provide services that are appropriate and culturally sensitive to the populations that they are serving. Diversity training for plan employees should be required. Further, plan materials, particularly marketing materials, should be subject to review by the Exchange to assure that there is no cultural or other bias in the plans' outreach to their enrollees or potential enrollees. Finally, all materials must also be tailored specifically to meet the particular needs of people with disabilities, including materials in Braille, large font, and other formats that comply with state and federal disability laws.

f. Care coordination programs and risk stratification to target individuals in highest need of services;

The Exchange should require QHPs to establish a robust method of assessing enrollees' needs as early as possible after enrollment. Such assessments should be able to measure assess enrollees' physical health, cognitive health and behavioral health needs. Such assessments will be particularly important in the Exchange, since many enrollees will have been without a usual source of care prior to enrollment and may have undiagnosed conditions and unmet needs. The assessment tool should be able to identify enrollees who would benefit from care management services. Priority should be given to QHPs that have established processes to identify enrollees' needs within 30 days of enrollment, or sooner if urgent needs are identified. This system must include care coordinators with sufficient links to the community to be able to locate identified beneficiaries, engage those patients with intensive face-to-face outreach, work with the enrollees to create a plan to improve health outcomes and decrease avoidable hospital admission and emergency department visits, and connect high-risk enrollees to community resources.

The Exchange should require QHPs to offer intensive interventions to high-risk enrollees with routine face-to-face care coordination that includes linkage to community services necessary to overcome social barriers to care, and, if applicable and appropriate, linkage to community-based behavioral health, primary care providers, and specialty providers. The Exchange must ensure that QHPs will stratify the intensity of interventions depending on the enrollee's level of need. Care coordination provided by paraprofessional non-licensed staff with the skills, training, and clinical supervision to work as part of a multidisciplinary team that includes qualified clinicians would fulfill the requirements for care coordination in a medical or health care home.

g. Implementing strategies to reduce and eliminate health disparities in ethnic and underserved communities;

We urge the Exchange to encourage QHPs to undertake activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings, in keeping with the Exchange's mission statement. Activities must

target specific groups including hard to reach populations and populations that experience health disparities due to low literacy, race, color, national origin, LGBTQ status, or disability, including mental illnesses and substance use disorders.

Another factor that should be included in the QHP certification and selection process should be an analysis of their capacity to support or complement state-wide and local public health and other initiatives to reduce or eliminate health disparities. These initiatives and programs should also include reproductive health disparities. Two examples of these types of programs are:

- The Public Health Advisory Committee to the California Department of Public Health recommended several health priority areas for the state in *Healthy California 2020 (*Public Health Advisory Committee, California Department of Public Health, *Healthy California 2020* (Apr. 30, 2011), *available at* http://cdph.ca.gov/services/boards/phac/Documents/PHAC-HP2020-Report-revision-one-3-4-11.pdf). These priority areas included oral health, access to health care, mental health, and tobacco use/substance abuse.
- Similarly, Los Angeles County has been an active member of the Partnership to Eliminate Disparities in Infant Mortality Action Learning Collaborative. The Collaborative focuses on eliminating racial inequities that contribute to infant mortality in urban areas of Los Angeles County (Los Angeles County, Partnership to Eliminate Disparities in Infant Mortality Action Learning Collaborative, *What is the Partnership to Eliminate Disparities in Infant Mortality Action Learning Collaborative? available at http://www.publichealth.lacounty.gov/mch/reproductivehealth/pedim%20alc%20website.pdf*).

The Exchange should ensure that QHP networks include safety-net providers who have an established history of incorporating these same objectives into their treatment of low-income communities, including but not limited to: HIV/AIDS clinics, public hospitals, women's health centers, federally qualified health centers (FQHCs), family planning clinics including Title X-funded reproductive health centers, and community health centers.

We recommend that there should be reimbursement and other incentives for QHPs to contract with FQHCs and other Essential Community Providers (ECPs) to provide health care, particularly if the ECPs satisfy other important priorities. These priorities include, but are not limited to:

- providing quality and comprehensive health services to medically underserved populations;
- implementing a plan to address health disparities that is compatible with the HHS National Health Disparity Strategy (*see* U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, NATIONAL PARTNERSHIP FOR ACTION, NATIONAL STAKEHOLDER STRATEGY FOR ACHIEVING HEALTH EQUITY, *available at* http://www.minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286);
- complying with language access standards (*see* U.S. Department of Health and Human Services, Office of Minority Health, National Standards on Culturally and Linguistically

Appropriate Services, http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15); and

- providing comprehensive primary, reproductive, dental, mental health/substance use and therapeutic care to individuals experiencing health disparities (e.g., people with HIV/AIDS, individuals with disabilities, and those with other chronic health problems).

We encourage the Exchange to use the QHP contracting process to improve health outcomes and implement activities that reduce health and health care disparities. Plans should be evaluated on their ability to comply with provisions of the Health Information Technology for Economic and Clinical Health Act, particularly the "Meaningful Use" (MU) requirements. Developing electronic health records and supporting systems will play key roles in identifying and eliminating health disparities (through data collection and other measures) and promoting consumer empowerment in taking an active role in their health care.

In addition, the Exchange must ensure that QHPs meet all applicable requirements for collecting and analyzing demographic data (including race, ethnicity, language, gender identity, sexual orientation, disability status). Without data, QHPs will have no consistent means of identifying and addressing disparities. We suggest that the Exchange require QHPs to collect demographic data on a minimum of 80% of their enrollees. Such collection must comply with the IOM standards for collecting race, ethnicity and language data (http://www.iom.edu/Reports/2009/RaceEthnicityData.aspx). In addition, we recommend that the process for collecting race/ethnicity data be consistent with the current U.S. Census methodology. In general, this means that the ethnicity data should be collected first (Hispanic, non-Hispanic) with race collected subsequently (Black, White). We know that race/ethnicity data collected in the opposite order during previous Census counts resulted in massive undercounts of groups who are people of color. The system should allow an assessment of LEP status at the same time as it collects race/ethnicity data. If someone triggers an indicator that they are LEP, the system should be designed to trigger access to written translations and oral language services as required by state and federal laws.

h. Success in fostering consumer involvement and shared decision making regarding health care services and treatment options.

At a minimum, the Exchange should require QHPs have in place procedures that permit subscribers and enrollees to participate in establishing their public policies, as required by the Knox-Keene Act and 28 C.C.R. § 1300.69.

In addition, the Exchange should give preference for plans with boards that are either publicly elected or appointed by those who are publicly elected. Boards that are publicly elected or appointed by those who are have a degree of public accountability and oversight that has made those entities more responsive to the needs of consumers. In addition, the Exchange should give preference to those plans that have in place local consumer advisory boards or committees familiar with the delivery of care and community resources in the local area. Those local consumer advisory committees should ideally include representatives of vulnerable populations,

including children, people with disabilities, limited English proficient enrollees and women of reproductive age. One model local consumer advisory board is Healthy San Diego's Joint Consumer & Professional Advisory Committee, which was established pursuant to California Welfare & Institutions Code 14089.05.

6. As the Exchange develops standards or policies regarding provider contracting and other provider management practices of potential Exchange carriers, in what ways might the Exchange consider and evaluate the following:

b. Demonstrated service history of caring for low-income populations and populations that have less experience with health insurance coverage;

There are several criteria that should be taken into account when looking at the provider networks offered by health plans seeking to participate in the Exchange. Health plans should be required to include providers in their networks who have experience with low- income populations because such providers will tend to be culturally sensitive and have the capability to linguistically serve enrollees whose primary language is other than English. In addition, health plans should be required to contract with family planning clinics who have experience in delivering reproductive health services in a confidential and culturally sensitive environment. Inclusion of these safety net providers who play a critical role in the delivery of health care to low-income communities will also assure their financial security and continued existence. The certification process should be seen as an opportunity to build on the current excellence of many of these providers and encourage them to adopt improved models of service delivery, such as certification as a PCMH as described above in our response to question 5(a).

Further, we believe that, to the extent possible, the Exchange should adopt policies that will lead to continuity of plans and provider networks over the various programs: Medicaid, Healthy Families, CHIP and Basic Health (if it is adopted). This goal is important to ensuring that individuals who are moving between these different programs because of fluctuating incomes or circumstances will be able, as much as possible, to remain with the same providers despite switching programs or payment-sources.

i. Mechanisms through which the Exchange can ensure that carriers monitor and evaluate the quality of network providers;

We recommend that the Exchange establish measurable outcomes to assess the quality of care provided by QHPs' networks. At a minimum, the Exchange must require QHPs to demonstrate that their plan providers are board-certified or at least board eligible, where applicable. We also encourage the Exchange to require the QHPs to credential their providers when they first join the plan, and every two years thereafter. Medicare's provider credential program could be a model for the Exchange's credentialing requirements.

Moreover, the Exchange should use existing HEDIS standards to monitor and measure improvements in quality of care outcomes for enrollees. The Exchange should measure reductions in morbidity, mortality, avoidable hospitalizations, adverse events and health-acquired infections compared to a comparable risk-adjusted population receiving care in the same geographic region. The Exchange should also explore developing additional HEDIS measures suited to the needs of the particular populations served by the Exchange.

Further, we recommend that the Exchange require QHPs to follow clinical practice guidelines developed by health care professionals in the relevant fields (e.g., the American College of Obstetricians and Gynecologists (ACOG)) and standard quality indicators (e.g., the percentage of patients who received evidence-based smoking cessation services).

In addition, the Exchange should encourage QHPs to convene local, randomly selected consumer panels to be periodically consulted about the quality of care; the panels should include individuals with special needs and should be paid to regularly provide information about their experience with plans.

The Exchange should require QHPs to administer annual customer satisfaction surveys to learn about consumers' experiences, including: their ability to get care when needed, see a regular physician, choose a personal physician, and obtain services they need for preventative care and treatment; the amount of time spent waiting to see a doctor; the courteousness and helpfulness of the plan; whether they would want to reenroll in the same plan; whether they would recommend the plan to a friend or family member. The Exchange should develop a standardized survey that is administered to enrollees in all QHPs. The Exchange should work with enrollees, advocates and survey development experts to make sure that the questions are appropriate and not misleading.

The benchmarks used to evaluate quality must be consistent across all plans and providers to allow the Exchange and enrollees to compare plans. These data should be used for the inaugural certification of QHPs, periodic review, and as benchmarks at the recertification stage.

In addition to the Exchange's own review of quality measures for the purposes of monitoring and certifying QHPs, the Exchange should also make quality of care data available to enrollees and potential enrollees. The process of assessing care quality must be transparent, publicly available, and easy for consumers to understand. Information derived through the monitoring process must be broadly disseminated and accessible online and in written form. And, like all information provided in connection with the Exchange, this information should be conveyed in a manner that is easily understood and accessible to people with low literacy, limited English proficiency, and disabilities. The format (though not the content) of the Office of the Patient Advocate's HMO Report Card (http://opa.ca.gov/report_card/hmorating.aspx) could be a model for such reporting.

Finally, the Exchange should conduct its own periodic evaluation of QHPs and specifically investigate and monitor plan performance where there has been a particular identified problem

or complaint that appears to go beyond an isolated case. The investigation or monitoring should be specifically targeted to address the particular identified problem or concern, whether network adequacy, fiscal solvency, provider reimbursement, appeals and grievances, or other specific areas. The Exchange should specifically impose sanctions, freeze enrollment or take other specific and necessary enforcement actions where ongoing problems are identified and have not been adequately addressed.

8. What opportunities are there for the Exchange to integrate, coordinate or build on health plan standards and contracting requirements in other state-administered coverage programs, including Medi-Cal, Healthy Families, and the California Public Employees Retirement System, and with federally-administered coverage programs such as Medicare and the Federal Employees Health Benefits Program? What opportunities are there to build on private sector standards, accreditation or contracting requirements?

The Exchange should encourage the participation of plans across different programs, so that enrollees moving between Medicaid, CHIP, the Exchange plans and, possibly, Basic Health will, to the extent possible, be able to remain with the same providers. To that end, plan standards and contracting requirements should be identical, or as similar as possible, to make it easier for health plans to serve enrollees in all programs. However, standards should not be lowered in order to achieve this. Rather, the minimum standards should be high for all categories, so that the care available to the lowest income persons in the Medi-Cal program will be as high as that available to persons enrolled in health plans through the Exchange. The Exchange should work together with the Department of Health Care Services, Department of Managed Health Care, and MRMIB to develop uniform standards and contracts to the extent possible. It should be made clear that the restrictive provisions in the ACA that set up requirements for segregation of funds and payment of special premiums for abortion coverage must not affect current policies in the Medi-Cal program.

10. What would be the potential implications and impacts to enrollees if California does or does not have a Basic Health Program? What are the potential implications for providers and for carrier participation in the Exchange?

We believe that a Basic Health Program, if implemented correctly, could provide an affordable alternative to purchasing coverage through the Exchange for low-income Californians. For Californians with incomes below 200% FPL, the premiums to purchase coverage in the Exchange, even with subsidies, are likely to place that coverage financially out-of-reach. For example, the Insight Center for Community Economic Development estimates that a single adult in San Joaquin County needs $1,861 per month (about 205% FPL) to make ends meet (Insight Center for Community Economic Development, The Self-Sufficiency Standard for San Joaquin County, CA 2011 (2011), http://www.insightcced.org/uploads/cfes/2011/San%20Joaquin.pdf.) For other parts of the state where the cost of living is higher, the amount needed is even higher (Insight Center for Community Economic Development, Self-Sufficiency Standard for California & Self-Sufficiency Calculator, http://www.insightcced.org/index.php?page=calculator). In 2010,

the California Budget Project estimated that, statewide, a single adult needed $2,537 per month (281% of the 2010 FPL) to get by (CALIFORNIA BUDGET PROJECT, MAKING ENDS MEET: HOW MUCH DOES IT COST TO RAISE A FAMILY IN CALIFORNIA? 4 (2010), *available at* http://www.cbp.org/pdfs/2010/100624_Making_Ends_Meet.pdf). At 200% FPL and below, most Californians are struggling just to meet their basic, subsistence level needs, and have little, if any, disposable income left to contribute toward the cost of health care services.

We expect coverage in California to be higher overall if the state implements an affordable Basic Health Program, compared to if it covers those with incomes below 200% FPL in the Exchange instead (*see* STAN DORN *ET AL.*, USING THE BASIC HEALTH PROGRAM TO MAKE COVERAGE MORE AFFORDABLE TO LOW-INCOME HOUSEHOLDS: A PROMISING APPROACH FOR MANY STATES 8 (2011), *available at* http://www.urban.org/uploadedpdf/412412-Using-the-Basic-Health-Program-to-Make-Coverage-More-Affordable-to-Low-Income-Households.pdf). Several studies have confirmed that affordability is key to enrollment in coverage (s*ee, e.g.,* NORTHWEST HEALTH LAW ADVOCATES, ASSESSING THE FEDERAL BASIC HEALTH OPTION: RECENT LESSONS FROM WASHINGTON'S BASIC HEALTH PROGRAM (2012), *available at* http://www.nohla.org/pdf-downloads/AssessingFederalBasicHealthOption1-10-12.pdf; Gery P. Guy, *The Effects of Cost Sharing on Access to Care Among Childless Adults,* 45 HEALTH SERV. RES. 1720 (2010); Amy J. Davidoff *et al., Lessons Learned: Who Didn't Enroll In Medicare Drug Coverage In 2006, And Why?*, 29 HEALTH AFF. 1255 (2010)).

Moreover, we expect that the Exchange will remain viable if California implements a Basic Health program. *See* DORN *ET AL.*, *supra* at 12-14. One study found that Exchange enrollment in California will only decrease from 2,583,000 enrollees to 2,051,000 enrollees (*id.* at 14). Another study also suggested that the Exchange will be viable if California implements a Basic Health Program, with enrollment declining from 2.5 million to about 1.8 million enrollees (MERCER, STATE OF CALIFORNIA FINANCIAL FEASIBILITY OF A BASIC HEALTH PROGRAM 22-23 (2011)). Even at 1.8 million enrollees, California's Exchange pool will be larger than any other states; the Mercer analysis notes that the Healthy Families program has maintained a viable pool with less than 900,000 enrollees (*id*).

We do not expect that the implementation of a Basic Health Program in California will significantly impact provider or carrier participation in QHPs. At least some analysts predict that California will be able to offer providers in Basic Health a 20-70% higher reimbursement rate than that currently offered in Medi-Cal (MERCER, *supra* at 20). These rates will be crucial in recruiting providers and carriers to serve the low-income population that will enroll in a Basic Health Program, especially those safety net providers and carriers that predominately serve Medi-Cal enrollees. But rates in the Exchange are likely to be even higher than those offered in a Basic Health Program, and thus the Exchange should also be able to recruit sufficient providers and carriers. We believe that, in conjunction with contracting requirements, the rate variation will encourage providers and carriers to develop diverse practices and networks that serve consumers across income ranges.

11. Under the Affordable Care Act, qualified health plans in the Exchange must include within the provider network those essential community providers, where available, that serve predominantly low-income, medically underserved individuals. What criteria and processes might the Exchange use to ensure the inclusion of essential community providers in qualified health plans it offers? What are the implications of such criteria for Exchange enrollees, providers and participating health plans?

The Exchange is required by 45 C.F.R. § 156.235 to contract with QHPs that include essential community providers in their networks. The federal regulations permit the Exchange to establish more stringent standards to ensure that enrollees have access to essential community providers, and the Exchange should do so. Essential community providers provide care to predominately low-income and medically-underserved populations who suffer from disproportionately high rates of illness and disability. In addition to providing more efficient and patient-centered care, the inclusion of essential community providers will support better continuity and coordination of health care, which are top tenets of the ACA.

It is essential that the QHPs include the full range of potential essential community providers that currently comprise the safety-net of providers who provide health care to low-income communities. Among the basic components of community health centers' in-house services are laboratory testing and medication dispensing. The Exchange should require QHPs to contract with essential community providers for the full range of services they offer, rather than only offering access to certain subsets of services. Safety-net providers who have an established history of serving predominantly low-income and medically-underserved communities, include, but are not limited to: HIV/AIDS clinics, public hospitals, women's health centers, free-standing birth centers, federally qualified health centers (FQHCs), family planning clinics including Title X-funded reproductive health centers, and community health centers. In addition, as to the unique health needs of women, it is especially important that QHPs be required to contract with Title X clinics, women's health clinics, and other publicly-funded family planning providers for the full range of covered services that they provide. For example, it should not be permissible for a QHP to exclude the contraceptive services that a women's health clinic offers. It is further critical that QHPs be prohibited from excluding a provider on the basis that the provider offers abortion services.

In addition to the usual range of providers and essential community providers noted above, QHPs must be required to ensure access to the following providers and services in their networks: interpreters, inpatient and outpatient rehabilitative programs, comprehensive rehabilitative and habilitative services, applied rehabilitative technology programs, wheelchair seating clinics (including access to wheelchair assessments) independent of durable medical equipment providers, specialty care centers (including those Ryan White Care providers serving people living with HIV), Genetically Handicapped Persons Program certified providers, non-coercive reproductive health services, speech pathologists (including those experienced working with nonverbal individuals, persons with developmental disabilities, and persons who need speech generating devices), occupational therapists, orthotics providers and fabricators,

physical therapists, case managers for those with significant non-medical barriers to care, Applied Behavioral Analysis (ABA) therapy, and low vision centers.

Rather than identifying a particular *number* of essential community providers for QHPs, we recommend that QHPs determine whether potential essential community providers have been successful in providing quality health services in medically-underserved communities for low-income populations (particularly those that are experiencing health disparities and poor health outcomes) that meet recognized scientific and medical standards that any provider would be expected to perform under any circumstance (s*ee generally* NATIONAL HEALTH LAW PROGRAM, HEALTH CARE REFUSALS: UNDERMINING QUALITY CARE FORWOMEN (2010)). Similarly, QHPs should be required to contract with essential community providers that routinely provide preventive health screenings and treatment including FDA-approved contraceptive drugs, devices and supplies consistent with HHS Required Health Plan Guidelines for those services (s*ee* U.S. Department of Health and Human Services, Health Resources and Services Administration, "Women's Preventive Services: Required Health Plan Coverage Guidelines," *available at* http://www.hrsa.gov/womensguidelines). The Exchange should also require that QHPs contract only with essential community providers that offer unbiased, accurate, and timely access and/or referrals to, and information about, health care services.

Finally, there should be reimbursement and other incentives for QHPs to contract with essential community providers to provide health care, particularly if the essential community providers satisfy other important priories, as described in our response to question 5(g) above.

20. What should the Exchange take into account (benefits covered, cost-sharing, networks, premium cost and care management features, etc.) as it develops the benefit plan designs to be offered through the Exchange?

All of these variables are important and need to be taken into account. However, low-income and vulnerable populations have qualitatively different health care needs than the average health consumer. For example, low-income children need proactive developmental screening and interventions to make up for a host of socioeconomic, nutritional, and environmental factors which may hinder their development. Therefore, Medi-Cal standards should be a model for developing the EHB package. In addition, the comprehensive benefits package must be offered with the minimal amount of cost-sharing allowed because it is well established in numerous studies that any cost-sharing impedes access to care for low-income populations. To the greatest extent possible, the Exchange should strive to contract with plans that reduce deductibles and other out-of-pocket cost-sharing to exceed applicable AV standards, even for subsidized enrollees. For low-income people, the adverse impact of unaffordable cost-sharing is likely to result in enrollees' forgoing care or even allowing coverage to lapse.

The Exchange should be prescriptive and aggressive in requiring that QHPs offer robust and comprehensive preventive benefits, as they are both cost-effective and must be offered without cost-sharing. Section 2713 of the Public Health Service Act (added by ACA § 1001) requires

coverage of four categories of recommended preventive health services, all of which are evidence-based and critical for securing the health of women, children, low-income individuals, and other vulnerable populations. Section 2713 prohibits insurers from charging co-payment or deductibles for covered preventive services. On February 16, 2012, HHS issued a bulletin explicitly confirming that the preventive services of section 2713 are incorporated into the EHB. The Exchange should explicitly require that QHPs cover all section 2713 services, including the eight specific women's health preventive services, without cost-sharing.

Further, section 2713(a)(4) is gender-specific, applying only to women, yet men are also critically in need of family planning services. In this regard California's experience is illustrative: the number of men served in California's Family PACT program, which provides no cost family planning to uninsured residences with income at or below 200% of FPL, increased by almost 10% in 2009, exceeding the growth rate of females accessing the program for the second consecutive year (Bixby Center for Global Reproductive Health, Univ. of Cal. S.F., Family PACT Program Report: Fiscal Year 2009-2010 (2011), http://bixbycenter.ucsf.edu/publications/files/FPACT%20Program%20Report_09-10). The Exchange should ensure that men also are able to gain access to annual counseling and screening for STIs and HIV/AIDs, as well as FDA-approved contraceptive methods (e.g., condoms), sterilization procedures, and family planning education and counseling. Finally, the Exchange should require QHPs to cover all FDA-approved contraceptive methods, drugs, devices and the attendant services without medical management limits or actuarial substitutions to ensure that men and women have access to the method that is most appropriate for their lifestyle and medical needs.

The Exchange should further require comprehensive and robust prescription coverage. Among other things, QHPs must offer a full range of prescription contraceptive drugs and devices, so that women can access the method of family planning that is best suited to meet her health and life needs. In this regard, the Exchange should adopt the Family PACT Program model of coverage of contraceptive methods.

The Exchange should ensure that abortion services are accessible to consumers. Restricting abortion coverage drastically impacts women's lives, primarily low and limited income women who are unable to afford the entire cost of an abortion procedure. The Exchange must therefore contract with issuers that cover abortion services. Section 1303(b)(2)(B)(ii) of the ACA requires insurance plans that cover abortion services for which federal funding is prohibited to collect separate payments from enrollees for coverage of such services. Individuals should be allowed to make their separate payments in one transaction and/or one transfer of funds. Last, only the plan purchaser should be responsible for the separate payment provisions, not each person in the family who is enrolled in the plan.

In the reproductive health context, it is the patient who must make the ultimate informed decision regarding which treatments and services are appropriate. Enrollees seeking reproductive health care must have access to all necessary information to make informed

decisions regarding their health needs. Benefits should never be restricted based on considerations outside of evidence-based medical standards.

The Exchange should ensure comprehensive perinatal and newborn preventive care, as well as post-partum care. In addition to prenatal medical visits and labor and delivery services, maternity benefits must include preconception care, prenatal dental care, health education, gestational diabetes programs, nutrition counseling, prenatal vitamins, lactation consultation, manual as well as hospital-grade electric breast pumps, screening for intimate partner violence, substance abuse screening and treatment, and other psychosocial services.

The Exchange must ensure that the provider network of each QHP is, in numbers and types of providers, able to assure that all covered services will be accessible to enrollees without unreasonable delay. The Exchange's minimum network adequacy standards should take into consideration the fact that many hospitals and clinics may, on religious and/or moral grounds, refuse to provide all of the covered services, and individual providers may refuse to offer covered services. These restrictions may limit access to comprehensive reproductive health services and information, as well as end of life care and information about treatment options. An adequate network must include providers that offer all covered services. Moreover, in the event that an enrollee is not able to access the reproductive health services that she needs within the network, in particular due to provider religious or moral objections, the QHP must be required to allow the woman to access services out-of-network without penalty, including in the case of emergencies.

26. Should the Exchange offer optional supplemental benefits in areas such as dental and/or vision care? And, if so, to what extent should the Exchange:

We believe that QHPs should be required to provide pregnant women with dental coverage that includes preventive care, dental conditions that may complicate pregnancy, as well as any other dental coverage that is medically necessary as a medical emergency or necessary as a condition precedent to other medical care, treatment or procedures (as required under Medicaid). We further believe that affordable and comprehensive adult dental and vision plans should be offered through the Exchange, so that potential access to these services will be easier.

a. Establish minimum standards, requirements, or contract terms, such as carrier type and license, provider network, and accessibility of services, applicable to qualified health plans and participating carriers offering health coverage be different for dental and vision coverage?

If such plans are offered, the Exchange should establish minimum standards similar to those established for QHPs.