FIRST FOCUS

MAKING CHILDREN & FAMILIES THE PRIORITY

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October 4, 2010

Jay Angoff
Director
Office of Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: OCIIO-9989-NC

Dear Mr. Angoff:

On behalf of First Focus, I appreciate the opportunity to respond to the Request for Comments (RFC) entitled "Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act" (PPACA) (75 Federal Register 45584 (August 3, 2010)). First Focus is a bipartisan children's advocacy organization dedicated to making children and families a priority in federal policy and budget decisions. Our core mission is to ensure that all of our nation's children are able to access the health care services they need and deserve.

First and foremost, we urge the Administration to ensure that the unique health and developmental needs of children are both considered and addressed in all of its rulemaking. Children make up one-quarter of the U.S. population yet their needs often are conflated with the adult population and are overlooked in key health policy decisions. While our comments below focus on what we view as the key issues for children, there is a children's angle to every issue relating to health care access, coverage and quality. As you move forward, we urge the Administration to consider the child perspective in every regulatory action you undertake in implementing national health reform.

Below are our comments for your consideration:

Comments Related to Section B. – Implementation Timeframes and Considerations

Protect Children Who Move Between Public Programs and Exchange Coverage.
While not directly addressed in this RFC, we urge the Administration to develop transition protections for children who are moved from Medicaid and CHIP into the Exchanges. As you are aware, there are significant fluctuations in coverage for this vulnerable population of children due to changes in a family's income over the course of a year. As the Exchanges are being designed,

we are confident that protections can be built into these coverage systems to ensure that children do not lose benefits or access to essential care because they move from coverage in Medicaid or CHIP into the Exchanges.

Comments Related to Section C. – State Exchange Operations

Language Access Services are Essential to Meet the Needs of Low-Income Families. Effective communication among families, health care providers, and insurance companies is essential for the delivery of high quality health care. First Focus is grateful that PPACA requires participating health plans to develop uniform explanation and summary of coverage documents that are culturally and linguistically appropriate. This is important progress but will require sufficient federal guidelines and oversight to be properly implemented.

Research findings, including extensive research by the Institute of Medicine, show that language barriers have an enormous impact on the health of individuals with limited English proficiency (LEP). These barriers often affect the delivery of care through the poor exchange of information, loss of important cultural information, misunderstanding of physician instruction, poor shared decision-making, or ethical compromises (e.g. difficulty obtaining informed consent). Linguistic difficulties also may result in poor appointment attendance, decreased adherence with medication regimes, and decreased satisfaction with services.

While the language-related challenges are significant, there is enormous opportunity to improve care for LEP patients and families by designing the Exchanges with their needs in mind. For example, the Exchanges should be required to use clear, concise language written at the lowest reasonable education level. The Administration must take steps to ensure that information can be understood not only by LEP individuals but also those with low literacy and health literacy levels. Exchanges should use consistent terminology and plain language definitions of health care terms, including the terms being developed by the National Association of Insurance Commissioners (NAIC). The NAIC terms will already have been tested with consumers through rounds of focus groups. We also suggest that – where possible – Exchanges use standardized language.

The Exchange's toll-free telephone hotline number should be clearly displayed on its website and at highly visible places throughout the community, such as on public transportation, in schools, libraries, grocery stores, and places of worship. Telephone operators who speak a variety of languages should be available and able to refer consumers to local resources. An audio component could be integrated into the website in various languages so that consumers could click to listen to information and understand where to go for additional assistance. Other forms of communication, such as newspapers and radio stations that are popular in racial/ethnic communities also could serve as useful forms of outreach.

Language access issues affect scores of American families. According to data from the U.S. Census Bureau almost 20% of the population speaks a language other than English at home. Over 24 million, or 8.7% of the population, speak English less than very well and are considered limited LEP for healthcare purposes. Ensuring that the language access requirements are comprehensive and strong will be essential if health care reform is to have an impact on these vulnerable populations.

Comments related to Section D. – Qualified Health Plans (QHPs)

Establish Guidance to Incentivize QHPs to Offer Products Both in the Exchanges and in Medicaid and CHIP. In order for children's coverage to be protected, we urge the Administration to ensure that there is significant overlap between plans that participate in CHIP and Medicaid and those operating in Exchange to ensure that children and other vulnerable populations can retain consistent access to the most appropriate providers. It would be particularly helpful if Medicaid managed care plans also offered comparable coverage products in the Exchange to mitigate the impact of churning.

Pediatric Subspecialists Must be Included in QHPs. To ensure a sufficient choice of providers, we urge the Secretary to bear in mind the needs of children with special health care needs. This unique and vulnerable population requires a very diverse group of pediatric sub-specialists in order to meet their extensive needs. To that end, we ask that the standards under development reflect this need by requiring each plan to have a diverse mix of sub-specialty providers and to ensure that those providers are also geographically dispersed throughout the state.

Establish Dental Standards and a Minimum Dental Coverage Benefit. We are grateful that PPACA requires the inclusion of pediatric oral health care as part of the essential benefits package. However, the statute provides significant flexibility to states by allowing dental coverage to be provided through a QHP or a stand-alone dental benefit either separately or in conjunction with a QHP. In order for children to receive the coverage they need to maintain their oral health it is important that the Administration establish dental standards for a plan to be eligible to participate as a QHP. While PPACA stipulates pediatric oral health care must be provided within the essential health benefit package, we are concerned that there may be some confusion about dental coverage given the two different paths toward coverage allowed. Specific guidance will be necessary to ensure that no matter whether coverage is provided through an Exchange plan or a stand-alone plan that the essential benefits package has been met by a QHP.

Working with oral health experts, we also urge you to develop specific guidance to determine a minimum dental benefit, which includes preventive and restorative services that, at a minimum, provide relief of pain and infection and restore/maintain function. In addition, we urge you to work with the Exchanges to establish quality standards for QHPs or stand-alone dental plans to evaluate their performance in meeting the oral health needs of enrolled children**.**

We are also concerned about the potential inequities of cost-sharing and premium subsidies for families that receive dental benefits through a stand-alone dental plan versus a QHP. We strongly urge the Administration to provide clear and detailed guidance to the Exchanges on the necessity for parity of all consumer protections including affordability with medical coverage for families that receive dental coverage through a stand-alone dental plan.

Community-Based Providers Must Include School-Based Health Centers (SBHCs). We urge the Administration to clarify that SBHCs are included among the community-based providers that are eligible to participate in the Exchanges. SBHCs provide essential services for children and

adolescents in the school setting to address their comprehensive medical and other health care needs. Oftentimes, this population relies on the center located in their school as their primary means of medical care. In some cases, the school-based health center is their only option due to a lack of services in their community. In order to facilitate the participation of a sufficient mix of QHPs in the Exchanges, essential community providers that serve the needs of the child and adolescent population must be included. We urge the Secretary to ensure that, as community-based providers, SBHCs are included in QHPs and eligible for reimbursement through the Exchanges.

Comments Related to Section G. – Enrollment and Eligibility

We applaud Congress and the Administration for their efforts to ensure that administrative red tape is no longer a barrier to getting Americans enrolled in coverage. As advocates for children, we have seen through CHIP implementation the difference that streamlined enrollment processes can make in reaching and reducing the numbers of uninsured. The data is clear that for enrollment of vulnerable populations to be successful the enrollment process must be readily accessible and easy to navigate. The "no wrong door" enrollment policy that was adopted as part of PPACA will go a long way toward directing individuals who seek coverage to the coverage that is most appropriate for them.

We applaud the Administration for continuing to make enrollment in Medicaid and CHIP a priority and for your efforts to extend the enrollment-related successes from these programs to health reform.

Medicaid and CHIP and Exchange Enrollment Systems Must Be Fully Integrated
PPACA explicitly requires that the enrollment and renewal processes for Exchange subsidies and Medicaid/CHIP be fully integrated. Because almost one-third of all children in America get their coverage through Medicaid and CHIP, and millions more eligible children remain unenrolled, it is critical that the Exchanges are required to conduct Medicaid/CHIP enrollment and have the infrastructure necessary to do so.

We recognize that allowing eligible individuals to enroll in Medicaid and CHIP when they apply for Exchange coverage (and vice versa) will require extensive collaboration between these entities. States should be encouraged to use their Medicaid agencies to conduct eligibility and enrollment processes for their Exchanges. This strategy has been a successful part of Massachusetts' efforts to create a seamless enrollment system. It is also important that Medicaid and CHIP staff are co-located within Exchange operation centers. In addition, any Exchange governance structures should include Medicaid/CHIP stakeholders, including consumers and advocates.

Citizenship Documentation Requirements Should Use the Existing SSA Data Match System. We are concerned about how the Exchanges will verify an individual's citizenship and urge the Administration to require the Exchanges to utilize data matching between the Exchanges and federal agencies rather than require individuals to submit documentation. As we saw when the Deficit Reduction Act was implemented, requiring citizens to provide documentation to verify their citizen status caused scores of eligible individuals to lose coverage because of paperwork requirements. Because the goal of health reform is to cover as many Americans as possible, it is

essential that HHS adopt policies that streamline the documentation process as much as possible and relieve applicants from the burden of providing documentation. All states have agreements in place with SSA for data matching in Medicaid and CHIP. States also have agreements in place with the Department of Homeland Security to verify immigrant status through the SAVE system. States should be permitted to amend their existing agreements to cover their Exchanges and should not require new documentation from applicants unless the data matching does not verify an appropriate eligible status.

Investments in Infrastructure Are Essential for Creating a Uniform System
Effective coordination requires a strong information technology infrastructure and interoperable system for eligibility determinations that allows linkages between the Exchanges, Medicaid, and CHIP. The system must ensure real-time eligibility or presumptive determinations, databases that can be used to verify eligibility, information retained for renewal, and single client identifiers for tracking individuals across programs. States will need extensive resources and technical assistance to build these systems. This will include the establishment of a federal uniform platform or open source technology that states can adapt, funding through the Exchange grants, and enhanced federal matching payments for Medicaid/CHIP system changes.

Recommendations for Developing Seamless Enrollment Systems
More specifically, as the Administration develops further guidance on developing systems that support seamless enrollment into the various public and private coverage programs, we urge you to:

- Develop simple and efficient procedures for families to report "change of circumstances" at the time of enrollment and during the enrollment year (if differences in income would affect eligibility and/or subsidy levels). When a person's eligibility changes, individuals should be automatically enrolled (with consent) in the appropriate program/subsidy level without requiring additional information from the consumer, though families should be clearly notified about how this change will affect them (i.e. differences in premiums, cost-sharing, provider networks, covered benefits, etc). To eliminate churning in Medicaid/CHIP, federal guidance should create a federal one-year continuous eligibility policy.

- Help states align program requirements, such as applying new MAGI and family size to Medicaid/CHIP, whether Medicaid will use current income or income from a prior year's tax return, and applying old rules to carved-out populations.

- Build coordination between the delivery systems used by the Exchange and Medicaid/CHIP plans. With people moving back and forth between subsidized Exchange coverage and Medicaid/CHIP, it will be important to identify ways to promote continuity of care. This could include ensuring that some plans offered in the exchange also serve Medicaid/CHIP beneficiaries, creating overlapping provider networks, and requiring plans to help facilitate transitions for those in the middle of treatment.

- For children, it is essential that states encourage applicants to apply for coverage even when enrollment periods are closed because the Exchanges will play an important role in identifying children who are eligible for CHIP and Medicaid, programs which are able to enroll eligible children into coverage at any time during the year.

- Develop strategies to ensure that families with mixed immigration status apply for and obtain the coverage for which they are eligible. This includes ensuring that eligibility questions are designed so that a citizen child of an undocumented immigrant is not mistakenly denied benefits based on the immigration status of the undocumented family member. The questions also should be minimized and clear information should be provided so that mixed status families are not afraid to apply to the programs for fear that information they provide will be used by immigration officials.

- Develop "safe harbors" of default Medicaid coverage for people lost between Medicaid/CHIP and the Exchange, such as when someone is deemed ineligible for Medicaid and Exchange subsidies because of differences in how the programs calculate and verify income and other eligibility data.

- Many of the individuals who are eligible for public benefits or health care subsidies under PPACA already are providing information about their income and family composition to state and federal government through their income tax returns. States (or the federal government, in the case of non-electing states) should add a single question to allow data for uninsured individuals to be shared with the Exchange to conduct a preliminary screening and pre-populate applications.

- During the first year of the exchanges, there should be an extended enrollment period that moves beyond the kick-off date, January 1, 2014. Many Americans will learn about PPACA's coverage requirement in the days and weeks leading up to and just after the roll-out date. Those who learn about the availability of Exchange coverage through publicity surrounding the launch date should be able to enroll without penalty.

- Online enrollment should rely on solutions that are designed to tailor screening questions based on how individuals answer earlier questions. This "hierarchical" approach would simplify the online enrollment process and help to ensure that people are directed to the most appropriate program (i.e. Medicaid, CHIP, or premium tax credits) to which they are most likely eligible, and ask for information needed for such program (rather than for all of the information needed to determine eligibility for all programs).

- While online enrollment will be an effective tool to get some segments of the population signed up for coverage, it is only as effective as users have Internet/computer access. Strategies should be implemented to broaden the availability of such access through the availability of kiosks in central locations, mobile units available in rural communities, training of assistors in community-based organizations, etc. Because low-income and other underserved communities disproportionately lack access to the Internet it is essential that more traditional enrollment processes continue to be available,

including allowing people to apply in person, by mail and phone, and through existing Medicaid/CHIP enrollment structures.

- Studies have found that applications started online often are not completed. Applicants may be interrupted in the process, may be missing needed information, or may be uncertain about how to proceed. Individuals who start an application online should be able to save their work and return to it at a later date – either online or in person, by phone, or with the assistance of a third party, such as a family member, community-based organization, or Navigator.

Comments Related to Section H. – Outreach

Medicaid and CHIP Outreach Strategies Should Be Used to Reach All Who are Eligible for Coverage. The development of the Exchanges, the expansion of Medicaid eligibility, and the new tax-based subsidies for purchasing Exchange coverage will dramatically change the health care options available to many Americans. Therefore, states will need to conduct significant public education activities to educate families about the coverage that is available. Medicaid and CHIP-related outreach and enrollment activities provide a wealth of experience and states should be encouraged to apply best practices from these programs. Outreach efforts involving partnerships with community vendors (such as grocery stores) and which include public facilities (such as libraries and public transportation hubs), hospitals, clinics and churches also should be conducted to reach consumers in places they live and frequent. Outreach efforts also must consider how to reach families who lack the time or ability to travel to a state office.

While data are limited on what is the most effective type of outreach activity, state experiences show that a successful model includes one-on-one contact or assistance with individuals and families. An important lesson from CHIP implementation is that broad-based outreach is not enough to reach all eligible individuals; targeted campaigns will be needed to reach populations who are less informed or more cautious about government programs. Community health, education and outreach workers with existing relationships in culturally-diverse communities should be an integral part of Exchange outreach efforts. Many states been successful in implementing such measures through grants provided to community-based organizations. This is a particularly important avenue for reaching those harder-to-reach families.

Community-Based Navigators Will Be Essential for Enrolling Hard-to-Reach Families
We appreciate the provisions of PPACA that require the Exchanges to establish "Navigator" grant programs to assist in public education activities, distribute enrollment information, and facilitate enrollment.

Given the limited resources that are likely to be allocated to Navigator grants, we urge the Administration to give priority to Navigators that have the capacity to reach harder-to-serve populations, including children in immigrant families, and uninsured children in urban and rural areas. In addition, we urge the Administration to ensure that a diverse range of organizations are

eligible to serve as Navigators. It is unlikely that a single type of organization will be equally well-suited to work with and assist a young parent who does not speak English, a small business owner seeking coverage for several employees, an older consumer with a pre-existing condition, and a disabled consumer who believes that she was inappropriately denied coverage.

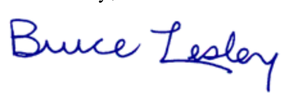
HHS also should encourage states to include as Navigators those community-based organizations that have the capacity to conduct outreach and screening for multiple programs. Already, there are a variety of models for such multiple benefit screening. These models have the potential to become even more effective if they are allowed, with permission from the individual, to access the data shared with the Exchanges from other programs. Based on the information needed to determine eligibility for Medicaid and health care subsidies, Navigators would be able to help families access a range of other benefits, such as Food Stamps and the Earned Income Tax Credit. Many community- and faith-based organizations that serve low-income populations would see it as consistent with their missions to help their families access the Exchanges and enroll in health insurance programs. These organizations are often cultural sensitive and trusted resources in their communities and can be valuable in reaching those who tend to be among the underserved.

To the extent that community-based organizations are given priority in serving as Navigators, as states develop their outreach and enrollment plans it will be important to ensure that HHS provides ongoing training and access to technical assistance to ensure that Navigators have accurate and complete information to appropriately guide those seeking enrollment assistance.

In closing, we want to underscore our appreciation for your efforts to ensure that health reform is a success for every American. We understand that the Administration officials who are charged with implementing health care reform have many demands on their time. As you continue to convene meetings with representatives from the states, the insurance industry, the provider community, labor unions, and other constituencies, we respectfully request that you work as closely with representatives from the children's community to be sure that the children's perspective is not lost in the larger policy debate. Along these lines, it would also be helpful for the Administration to consider appointing representatives from the children's community to serve as or in addition to consumer representatives who are slotted for service on the various commissions and boards that have been established under PPACA.

We are grateful for the opportunity to comment on this important policy. We would be happy to provide any additional information you may require.

Sincerely,



Bruce Lesley
President