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Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244

Attention: CMS-2380-P

Basic Health Program; State Administration of Basic Health Programs; Eligibility and Enrollment in Standard Health Plans; Essential Health Benefits in Standard Health Plans; Performance Standards for Basic Health Plans; Premium and Cost Sharing for Basic Health Programs; Federal Funding Process; Trust Fund and Financial Integrity.

The American College of Physicians appreciates the opportunity to comment on the Basic Health Program (BHP) proposed rule. ACP is the largest medical specialty organization and second-largest physician group in the United States, representing 137,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum, from health to complex illness.

If implemented effectively, BHP-based plans could facilitate continuity of coverage for patients transferring from Medicaid to supplemented private coverage, minimizing the churn effect that undermines care coordination and patient satisfaction. The BHP's emphasis on innovative delivery system reforms such as "care coordination, case management, the use of incentives to promote preventive services and encourage enrollee involvement in health care decision making, such as the ability for enrollees to select their providers," will encourage high quality, high value, patient-centered care. ACP has long supported the development and establishment of the patient-centered medical home and patient-centered medical home-neighbor models that emphasize physician and other health care professional collaboration, preventive care, and the delivery of evidence-based services provided in a culturally and linguistically sensitive manner. By contracting with BHP-based standard health plans that feature such models, the BHP may help the nation's health care system evolve towards higher quality, patient-focused, integrated care.

ACP respectfully makes the following recommendations:

600.150 – Enrollment assistance and information requirements. ACP supports requiring states to mandate that BHP-based standard health plans make available current provider lists to enrollees. Standard health plans should be required to provide and maintain a provider directory that is regularly updated and readily accessible in electronic and other formats. Provider directories must also be available for use by people with disabilities and those with limited English proficiency.

600.415 – Contracting Qualifications and Requirements. ACP appreciates language in this section that establishes standard health plan contract provisions on network adequacy, service provision and authorization, and quality and performance, among others. To the extent possible, ACP requests that standard health plan contracts require that physician performance measure and clinical guideline sets be coordinated among state-administered health insurance programs. Doing so will help ensure that all insurance programs are using evidence-based guidelines and measures, facilitate better physician adherence, and reduce service duplication and administrative burden.

Further, to encourage and evaluate quality of care among standard health plans, and managed care plans in particular, contracts should require plans to:

- Establish mechanisms to incorporate the recommendations, suggestions and views of enrollees and participating physicians and other health care professionals that improve quality of care into:
    - Medical policies of the plan (such as policies relating to coverage of new technologies, treatments and procedures);
    - Quality and credentialing criteria of the plan;
    - Medical management procedures of the plan;
- Monitor and evaluate high-volume and high-risk services and the care of acute and chronic conditions.
- Evaluate the continuity and coordination of care that enrollees receive.
- Have mechanisms to detect both underutilization and overutilization of services;
- Use systematic data collection of performance and patient results, provide interpretation of these data to its practitioners, and make needed changes.
- Make available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health care coverage options.

600.420 – Enhanced availability of standard health plans. ACP supports efforts to enable patients to choose from a wide variety of standard health plans. Basic health programs should ensure that managed care enrollees have a point-of-service or similar coverage option that enables them to obtain care from a physician outside of the plan's network. The formation of BHP regional compacts must not dilute strong consumer protections including, but not limited to, state regulations on fiscal soundness, prompt payment, and consumer grievance and appeals rights.

600.425 – Coordination with Other Insurance Affordability Programs. The College supports requiring standard health plans to ensure coordination for the provision of health care services to promote enrollee continuity of care between Medicaid, CHIP, Exchange and other state-administered health insurance

programs. Since the BHP may act as a bridge between Medicaid and private insurance plans, it is essential to facilitate continuity of care as patients transition to other insurance programs. Physicians must be informed when a patient is transitioning to another insurance program or plan so care and treatment regimens can be coordinated with other physicians and other health care professionals. Patients must also be clearly informed in advance of any restrictions on their access to specialists that may result from their choice of alternative plan or delivery system.

600.525 - Disenrollment procedures and consequences for nonpayment of premiums. ACP is concerned that BHP-based plans will be permitted to pend physician claims for enrollees who have entered the latter two months of the grace period, based on the standards codified in 43 CFR 156.270. Like the qualified health plan grace period on which it is based, this policy threatens to place an undue financial burden on physicians who provide care in the two months prior to coverage termination and may violate state laws that require prompt pay of clean claims. While ACP supports giving patients time to pay for insurance-related costs, the College urges CMS to disallow insurers to pend claims during the 31-90 day portion of the grace period. To help physicians prepare for any grace period-related repercussions, BHP-related standard health plans should be required to electronically notify physicians as soon as practicable (i.e., at the point of service) that a patient has entered the grace period.

600.605 – BHP payment methodology. ACP supports efforts to ensure that patients enrolled in BHP-based standard health plans will be able to access a wide range of primary care and specialty physicians. However, the BHP's financing structure and potential inclusion of limited network plans may undermine patient's access to preferred physicians. The rule proposes to pay states at 95% of the amount of cost-sharing reduction assistance that enrollees would have received in a marketplace-based health insurance plan, even though the statute does not specify the payment requirements for such assistance. The College is concerned that this policy may compel BHP-based standard health plans to develop narrow provider networks in an effort to curb costs and hedge risk. Numerous reports have found that Exchange-based qualified health plans are offering narrow networks of physicians and other health care professionals, excluding hospital and physician groups that are popular with patients. ACP requests that, given the ambiguity of the statute, cost-sharing reduction assistance payment levels be 100% of Exchange-based assistance to help ensure that patients are able to access a variety of physicians without facing excessive cost-sharing responsibilities. Further, BHP-based standard health plans should be prohibited from including "all-products" clauses in physician contracts, which automatically enroll physicians in a plan's network, often without their knowledge or direct consent and regardless of the physician's ability to absorb additional patients.

Conclusion. The Basic Health Program has the potential to provide an important bridge of service for those transitioning out of the Medicaid program. If implemented properly and with the input of physicians and other stakeholders, the BHP may also help to encourage greater use of innovative delivery system reforms that lead to high value, high quality care. However, substantial safeguards need to be in place to ensure that patients are able to access preferred physicians without exposure to excessive cost-sharing. Grace period requirements should be amended to prohibit claims from being pended and unreimbursed. Performance measurement sets and clinical guidelines should also be standardized across plans to enable continuity of care. Finally, since the BHP presents a new and innovative form of insurance coverage,

BHPs must educate patients and physicians on the differences between standard health plans and existing insurance models.

Sincerely,

Molly Cooke, MD FACP
President