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October 4, 2010

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

RE: Exchange Comments

Community Health Councils (CHC), writes today to share our recommendations for the development of standards for the operation of the State Exchanges. CHC is a community-based health promotion, policy and advocacy organization based in South Los Angeles working to improve the health and access to quality health services for low-income communities.

As states begin to outline what the Exchange will look like within their own political landscape having national standards will ensure that consumers will receive affordable and quality care as is the intention of the Affordable Care Act. It will be critical that state Exchanges:

- Be designed on policies and systems that seek to bring consumers readily into coverage rather than screen them out;
- Provide sufficient information to allow families to compare and understand all available healthcare coverage options;
- Provide a simple, easy enrollment process and procedures that enable families to obtain and maintain health coverage and navigate the healthcare system; and
- Close the gap between the coverage rates of racial and ethnic minorities and whites.

To that end we offer the following responses to sections D “Qualified Health Plans”, G “Enrollment & Eligibility” and H “Outreach” to help aid the Department of Health and Human Services prepare its guidance on the State Exchanges.

D. Qualified Health Plans (QHPs)

2a. What issues need to be considered in establishing appropriate standards for ensuring a sufficient choice of providers and providing information on the availability of providers?

Adequate Provider Access and Quality of Care: Qualified health plans within the Exchange must be able to demonstrate sufficient provider networks and meet key national and state quality performance standards. One of the greatest challenges to the effective implementation of the Exchange and expansion of the Medi-Cal program is the inequitable distribution of healthcare resources. Exchange beneficiaries should have timely, geographic access to high-quality medical services. The Exchange needs to create incentives and stimulate a more equitable distribution of healthcare resources throughout the state, particularly in rural and underserved urban areas. Given this disparity in resources, particularly in the private commercial market, we request that health plans in the Exchange be required to contract with local physician groups and traditional

safety net partners such as community health centers. Furthermore, health plans in the exchange and their contracted providers should be evaluated by a set of benchmarks to ensure quality services, timely access, comprehensive care, and improved health outcomes. States should require participating health plans demonstrate progressive movement towards integrating the principles of a true patient-centered medical home and accountable care organization as criteria for initial and continued participation in the exchange. Payment for services should be linked to performance with an accounting for the acuity of illness and health needs of their respective patient populations. Finally, contracted providers should receive training on how to become a full-scale Medical Home and Exchange beneficiaries should receive ample education on available resources within the Medical Home model.

Create a Culture of Wellness. Similar to a “culture of coverage”, the Insurance Exchange should promote prevention and wellness strategies in its intent and mission. We ask that all qualified health plans within the Exchange establish and promote links to community-based and population-based public health services. This should be done via readily accessible helplines, websites and marketing campaigns designed to promote disease prevention and wellness as a way of being.

G. Enrollment and Eligibility

1. *What are the advantages and issues associated with various options for setting the duration of the open enrollment period for Exchanges for the first year and subsequent years? What factors are important for developing criteria for special enrollment periods?*

Open Enrollment & Special Annual Renewal Periods: If the experience of the roll out of the SCHIP program holds true in the case of the state Exchange – achieving desired enrollment levels in the program will take time and a significant investment of resources. There continue to be a great many questions and uncertainty about who benefits under health reform, what and when they will be eligible for coverage. There will also be a level of distrust as well as inevitable “glitches” in the system the first year which must be overcome. It will be important to recognize that not every consumer will have the expertise and knowledge necessary to make the best choice of plan for themselves and their families. There must also be a distinction drawn between the initial application/enrollment and renewal period for individuals and groups. If the goal is to truly provide health coverage to the millions of uninsured Americans, the system must be designed to cover the uninsured at whatever point they become eligible and choose to seek coverage. There should be no artificial delays or barriers. We therefore recommend the adoption of an ongoing open enrollment similar to the Medicaid and CHIP for individuals. Similarly – we recommend open enrollment for at least the first three years of the program for groups – and no less than quarterly going forward. Annual renewals for individuals would therefore be based upon their enrollment date as is the case in the Medicaid and CHIP program. The annual renewal for groups should also be based on the date of enrollment for at least the first three years. Individuals and groups should be afforded the opportunity to change plans at least one time annually (similar to the Part D Medicare structure) and ability to change plans for good cause. Furthermore, should HHS conduct an annual open enrollment or renewal period, a waiver process should be developed for families who have extenuating circumstances to permit them to add a family member to their coverage outside of the open enrollment period. Additionally, we recommend that loss of eligibility for Medicaid and CHIP should be considered qualifying events for purposes of triggering a special enrollment period.

2. *What are some of the key considerations associated with conducting online enrollment?*

Effective Use of Technology: We support the creation of web-based applications for enrolling and renewing families’ health care coverage with the expectation the system will include:

- The system results in the actual enrollment of the applicant and not simply screening for eligibility;

- The need for copies of supporting documentation is minimal if required at all and supported through the use of a system for tracking and linking applications and supporting documents;
- The development of enrollment call centers and funding of community based outreach workers to provide application assistance to families;
- The ability to provide applicants and enrollees updates on the status of their applications, reminders (paperwork/deadlines) and updates electronically;
- Be “consumer friendly” and developed to provide consumer information at an appropriate literacy level with multiple language options;
- The ability to immediately connect with a local navigator if they begin to experience challenges while completing their online applications and that navigators (with the individual’s consent) are able to access that application to avoid duplicate applications in the system.
- The use of electronic correspondence and connections to social networking sites for those consumers who are comfortable with this medium.

However, there continues to be a digital divide with 34% of American adults (including over 50% of households under \$30,000) not using high-speed internet connection.¹ It is imperative that alternative methods of enrollment such as by mail and phone also be available. Current community based outreach efforts for Medicaid and CHIP must be maintained and adequately funded to assist consumers in the application process and/or direct them to the online enrollment resources. Application venues must stay intact, such as in-person capacities at outstations located at the county human services department offices, or at outstations located at clinics, hospitals and schools.

We also believe the online enrollment system should be linked to a website that provides a “one-stop-shop” for enrollees. This would include an ongoing resource for consumers on the Exchange, how to enroll, make changes, add family members, make required payments and access their health plan specific site.

Centralization of Data and Linkages Across Systems: In order to make online enrollment truly effective, data submitted at the time of application should be stored in a central repository that is capable of linking and transferring data to other systems as appropriate. These include all systems that the consumer will connect with post enrollment such as the chosen health plan and provider. This will eliminate any administrative burdens of re-entering data and remove the onerous task on the consumer of having to complete additional forms that contain similar information as what was submitted at time of enrollment. However, it is important that privacy protections be set up for consumers at every point of contact with another system

Adequate Funding and Support for Technology Development: Local communities will need the Federal and State governments’ investment and standardization of such systems to facilitate access to and use of such technologies for “navigators” and others who participate in the enrollment process on behalf of low-income families. Currently, while there have been progress in this arena at the local level, it is very expensive to adapt such technologies and/or interfaces to such technologies with the varied platforms in use by local safety net delivery systems, health plans and County governments. Funding should also take into consideration the amount needed to develop strong privacy protections.

- 3. *How can eligibility and enrollment be effectively coordinated between Medicaid, CHIP, and Exchanges? How could eligibility systems be designed or adapted to accomplish this? What steps can be taken to ease consumer navigation between the programs and ease administrative burden? What are the key considerations related to States using Exchange or Medicaid/CHIP application information to determine eligibility for all three programs?***

¹ <http://pewinternet.org/Reports/2010/Home-Broadband-2010.aspx>

Per section 1413 of the bill there are a set of requirements that the State must adhere to in establishing their exchange system (single application, simplified enrollment systems and coordination between public programs). In order for these key components to be effective we recommend the following:

Integration of Medicaid, SCHIP and Exchange Enrollment & Eligibility Systems: to simplify and maximize enrollment, universal applications should make the distinctions between Medicaid, CHIP and Exchanges “invisible” to families. Should States continue to keep separate agencies to administer these programs, these agencies should have the ability to electronically transition applications and all necessary documents to another program in real time and without any burden on the client. The Exchange enrollment systems should be based on best practices and innovations that ease enrollment procedures and create a seamless transition between public and private programs. This is achieved through simplified forms and documentation requirements; the alignment of program benefits, policies, procedures and delivery systems; and the coordination and bridging of different programs. To the extent that there will be differences in parameters within Medicaid populations (i.e., “newly eligible” vs. currently eligible), these should not drive different systems, processes, etc. within the enrollment processes. We strongly advocate for simplification of the Medicaid eligibility process to facilitate the desired “culture of coverage” with retrospective tracking and reporting, if necessary, to distinguish the newly eligible vs. currently eligible groups.

Linguistically and Culturally Competent Systems and Materials: All systems and consumer-related informational materials must meet the highest cultural and linguistic standards. All applications (paper & electronic), promotional materials/systems (i.e. website, toll free lines, media) and program documents (i.e. notices, required forms) should also be developed according to recommended reading levels of 5th grade², but should be lower based on population needs and assessment. In addition, these items should also be developed in multiple languages as determined by each state or region.

4. *What kinds of data linkages do State Medicaid and CHIP agencies currently have with other Federal and State agencies and data sources? How can the implementation of Exchanges help to streamline these processes for States, and how can these linkages be leveraged to support Exchange operations?*

Building and Improving Linkages with Other Federal & State Programs: To reach the uninsured – the state exchange must be linked with a wide variety of not only other health and human service resources, but the larger systems consumers access relating to employment, transportation, housing and tax reporting. However, a distinction must be drawn between “linkages” and “sharing” date. The function and purpose of establishing “linkages” is to ensure broad knowledge and access to the program and tends to be informational or referral in nature vs “sharing” which implies the exchange of consumer data between agencies. State Medicaid and CHIP agencies have traditionally linked to other health and social service programs such as WIC, TANF and SNAP as well as educational institutions such as free/reduced lunch program. These linkages have varied in their strength from complete enrollments into a public health care program to simple dissemination of information and referrals to a local hotline. It will be important for HHS to provide guidance for strengthening these linkages as well as bringing together the Federal Directors/Administrators of these and other programs to develop an integrated work plan for health reform. Additionally, HHS should assist states to develop new nontraditional linkages with other agencies/program that consumers may connect with such as Housing, Labor, and Small Business Loan Programs in order to create a true “no wrong door” model. Furthermore exchanges

² Maximus Center for Health Literacy. The Health Literacy Style Manual. Available at <http://coveringkidsandfamilies.org/rsoruces/docs/stylemaual.pdf>.

should be able to create a one-stop model linking consumers to those agencies that they have an identified need for. However it will be important that in order to ensure that consumers feel safe and confident to enter the Exchange, “linkages” provide for the timely enrollment into the program but not be used to report to such agencies like US Immigration and Customs Enforcement for punitive reasons.

5. *How do States or other stakeholders envision facilitating the requirements of Section 1411 related to verification with Federal agencies of eligibility for enrollment through an Exchange?*

Real-Time Data Match Between State & Federal Programs: Currently most data exchanges or matching are run periodically in batch format rather than in real-time. We encourage the development of an interface that can provide real time data matching between Medicaid, CHIP and the Exchange and the appropriate state and federal agencies such as the Social Security Administration, the IRS, and state employment agencies. However – in the interest of “bringing the uninsured into coverage” – we would encourage the need for data verification be kept to a minimum and self-declaration used when possible. It is also important that the use of the data and data matches be limited to verification of eligibility for health benefits and not the exchange of information for other purposes (e.g. immigration, tax collection). Use of a unique identifier (such as a Social Security Number) will help identify current or past enrollment in these programs and allow faster and more accurate linking of information. We also recognize the need for some systems to ensure individuals do not already have existing coverage through their employer (if it would preclude them from being eligible for public programs) or to otherwise identify up-to-date coverage information, as needed for service delivery and cost-claiming purposes. Additionally we recommend that HHS look at the federal systems that States will be required to link to and make any improvements on those systems now. And required specifications should be communicated to States immediately in order to prevent States from spending additional time and money developing a work around later to connect to federal systems.

6. *What are the verification and data sharing functions that States are capable of performing to facilitate the determination of Exchange eligibility and enrollment?*

Build Upon and Make Improvements to Existing Systems: States have existing systems that have worked effectively at assisting with eligibility and enrollment. For example ,California links to the US Postal Service for valid address verification and conducts a vital records match for birth records. There are also systems being used which provide access to a wealth of information but the retrieval methods are archaic such as in California where information from the Social Security Administration is received through a batch process. We recommend that the Federal Government take advantage of what has worked in states and share that information across the country, requiring states to link to useful sites and providing technical and financial support to help states make these linkages or improve linkages they currently have.

7. *What considerations should be taken into account in establishing procedures for payment of the cost sharing reductions to health plans?*

Centralized Payment System: Just as the Exchange systems should streamline and simplify requirements, paperwork and systems, Exchanges should create simplified methods for consumers to make their premiums. In California systems like California Public Employees’ Retirement System which manages retirement benefits for more than 1.6 million public employees, retirees, and their families and the Healthy Families (SCHIP) Program beneficiaries pay their premiums directly to one source versus to the health plan. This reduces administrative burdens for health plans and allows consumers to maintain the same payment source no matter what changes may occur with their plans. Building on the concept of the “one-stop-shop”, the website and administrator for the Exchange should represent the

centralized payment system for all related cost. Exchanges should also offer a variety of payment options and credits for payments paid in advance.

Compatible Electronic Systems: Enrollment systems and health plan systems must be able to communicate “easily” through standardized formats that minimize administrative costs to both systems. To the extent that participants may be changing eligibility status and, therefore, subsidy/cost-sharing parameters through the course of the year, it is imperative that such changes are able to be transmitted easily and timely to health plans to avoid the creation of increased administrative costs for plans.

H. Outreach

1. ***What kinds of consumer enrollment, outreach, and educational activities are States and other entities likely to conduct relating to Exchanges, insurance market reforms, premium tax credits and cost-sharing reductions, available plan choices, etc., and what Federal resources or technical assistance are likely to be beneficial?***

In order to provide multiple access points for families, a wide net must be cast throughout the community to maximize resources and the capacity of public and private stakeholder assisting families. This should include:

Comprehensive Public Information/Media Campaign: The success of the Exchange will in part be dependent on the investment in, and design of the public information campaign to educate individuals on new coverage options and changes to existing coverage options. The campaign must be culturally and linguistically appropriate and utilize a wide range of traditional mass media and new marketing strategies. Federal technical assistance would be helpful in developing standardized, “user-friendly” campaign materials and formats for presenting coverage options. However, these materials should be adaptable for specific populations and regions. They should also be thoroughly vetted by consumers and other stakeholders prior to implementation at the Federal and State level. Any public information campaign should also allow people to sign up to receive information either through email or phone alerts/information.

The federal government should also play a role in the public information campaign as it did with SCHIP. This should include sponsoring public service announcements, garnering public figures as national spokespersons; and providing a national information website and call center that directs consumers to their state program.

Community Outreach and Enrollment Services: The use of technology and mass media must be supported by an equal investment in outreach and enrollment at the community level to ensure all individuals and families are informed and have access to all of the available programs. Community outreach and enrollment is necessary to reach those who are hesitant, need more information or assistance, are “hard to reach”, or are otherwise marginalized. To provide this service and build this capacity, the Exchange should capitalize and build upon the existing statewide network of organizations that provide Outreach, Enrollment, Retention and Utilization (OERU) services for Medicaid, CHIP and other public health programs.

Adopt a “No Wrong Door” Approach: In order to reach all eligible individuals, the state’s public information campaign must provide a wide variety of points of services and information. Promoting the spectrum of available coverage programs through the State and local public and private agencies and organizations (i.e. Schools, WIC, county agencies, health care providers) that routinely interface with families and newly eligible adults increases the likelihood they will learn about the options available to them, utilize services and know where to go for assistance when needed.

Demonstrate Cultural and Linguistic Competency & Prioritize Outreach to Racial & Ethnic Minorities:

Given the racial and ethnic diversity across the country and that racial and ethnic groups have higher incidences of disease; the Navigator Program must employ staff who are bilingual and bicultural to enable them to sufficiently serve diverse communities. Navigators must speak the most common languages in the community they serve and develop outreach strategies that will uniquely address the needs of the specific population being served. Additionally, all consumer-related promotional and informational materials and services must meet the State's highest cultural and linguistic standards. This should include, but not be limited to the dissemination and exchange of information via websites, toll-free telephone lines, media, required forms, and correspondence to the consumer.

Create a Culture of Coverage: The marketing and outreach campaign must be designed to establish a "culture of coverage" in which maintaining health insurance coverage becomes a norm for all children and families. This takes form in the messaging that occurs during the public information campaign, enrollment process and receipt of care. There can be no stigma or perception of a "second tier" system. The public must see subsidized coverage through the Exchange as being equal in quality as coverage that is not subsidized and employer-based coverage. Establishing and enforcing standards for customer service can achieve this.

2. What resources are needed for Navigator programs? To what extent do States currently have programs in place that can be adapted to serve as patient Navigators?

For the Navigator programs to be successful State Exchanges should incorporate the following:

Build Upon Existing Statewide Networks of Outreach Organizations: Community based organizations, clinics and other safety net providers are well positioned throughout each State with staff who are knowledgeable about their state's health care infrastructure, already building their comprehension of the health reform law, and ready to help educate, enroll, and assist families during the expansion of the Medicaid program and implementation of the Exchange. However, as States grapple with deficits and often, these programs are the first to be cut, it is not certain that these networks will be ready in 2014 to do their job well. Therefore, we encourage the Federal Government to identify support for these existing networks to allow them to build up their capacity and even assist with public awareness activities around the Health Care Law prior to 2014.

Provide a Full Complement of Services Beyond Outreach and Enrollment: Navigator Programs should be designed to implement a full spectrum of OERU services that include: outreach & screening clients for all programs; helping clients to complete paperwork; following up with clients to verify enrollment, utilization of services, and renewal of coverage. The Navigator should also be a conduit for public health and prevention messages stressing the importance of obtaining health care coverage, prevention services and the benefits of a medical home. Once families and individuals are enrolled into health care coverage, there needs to be an established set of practices that help them to retain coverage and navigate the system to utilize benefits. Again, the Navigator can be key to providing education on accessing health care programs, benefits, policies and navigating the health care system. In order to ensure that services are appropriate, reduce barriers, and are provided in a professional manner meeting the needs of the consumer, we recommend the development of standards and guidelines that are adaptable for States and Local Communities and properly vetted through a stakeholder process.

Provide On-Going Comprehensive Training Programs to Develop a Knowledgeable and Competent Workforce: Navigator Programs should follow a standardized set of trainings required for staff who will be assisting clients that include the technical knowledge and skills needed to effectively assist client while remaining current on policy change in the federal, state and county regulations. Trainings should

also provide opportunities for entities to share challenges and strategies for troubleshooting with clients and dealing with the health care system. Specialized training programs should also be developed to enhance the skill capacity of navigators for more complex issues (i.e. encouraging clients to utilize preventive services). States should have separate funding for training organizations to provide these services to organizations. Furthermore we recommend standardization in curriculums, with adaptability for specific States and regions, vetted through local community based organizations and health advocates.

Provide Adequate and Sustainable Funding: Navigator Programs must be fully funded to provide a comprehensive set of services beyond outreach and enrollment. The sustained funding will help organizations to retain their workforce and establish a set of common standards and guidelines around OERU activities and services. Each State should be required, (if not already done), to conduct a full analysis of what it would take to provide a comprehensive set of services, taking into account regional concerns such as the number of uninsured and “hard to reach” populations. States should also identify funds for ongoing training, marketing, and evaluation. For a “culture of coverage” to take hold, administrative claiming for outreach/enrollment activities should (like the Medicaid process) be supported with significant federal matching. The current model of 90% federal financing of Medicaid administration within State/County social services but much lower federal sharing for community-based or provider-based outreach and enrollment work thwarts the achievement of strong, sustainable, coverage “feeders”.

3. **What kinds of outreach strategies are likely to be most successful in enrolling individuals who are eligible for tax credits and cost-sharing reductions to purchase coverage through an Exchange, and retaining these individuals? How can these outreach efforts be coordinated with efforts for other public programs?**

Based on experience, the following are a few successful strategies:

Conduct Consumer Education to Inform Families About Programs, Benefits and Resources: One-on-one education includes verbal and written information to help educate families on the enrollment and renewal process, the importance of utilizing health service and general information about procedures, accessing services and resources for families. This may happen during an outreach event/activity, at the time of enrollment, or anytime after enrollment (during follow-up calls or on a periodic basis for individual or large groups).

Conduct community outreach events to educate and provide general information and resources to assist families. Community outreach events are used to educate and provide general information and resources for assistance to families. Outreach events are not usually considered high-yield enrollment activities but are used to spread awareness on available coverage program options. They typically connect families with enrollment sites and allow families to set up an enrollment appointment.

Establish local Helplines to assist families with general information and resources for assistance. Helplines provide quick and up to date access to information about different health care programs. These lines can connect consumers with local agencies providing enrollment services or the programs themselves. Helplines should be accessible via an 800 number and websites. These websites should also allow consumer to sign up to receive email and phone alerts/information.

Provide designated staff in community settings serving eligible individuals and families. By providing enrollment assistance directly within the communities of the target population, community-based organizations effectively address any transportation, language or trusts barriers. Because they work

directly in the community these organizations are able to access and support an extensive population eligible for multiple coverage programs.

We look forward to working with you to build upon the strengths of our current healthcare coverage system and to make needed reforms to improve quality, access, and affordability of care for children and families. We hope that you will look to our coalitions to help shape the direction and implementation of the Insurance Exchange and look forward to working with you. Should you require additional information or have any questions, please feel free to contact Sonya Vasquez, Policy Director, at 323.295.9372 extension 235.

Respectfully,

A handwritten signature in black ink, appearing to read "L. Galloway-Gilliam", is centered on a light gray rectangular background.

Lark Galloway-Gilliam, MPA
Executive Director