



October 31, 2011

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

RE: Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans: Proposed Rule CMS-9989-P

Dear Sir/Madam:

On behalf of the National Alliance on Mental Illness (NAMI), I am pleased to submit the following comments on the proposed regulations regarding the establishment of the health insurance Exchanges and qualified health plan (QHP) requirements of the Affordable Care Act. NAMI is the nation's largest organization representing children and adults living with serious mental illness and their families. Our 1,100 affiliates in all 50 states are committed to full implementation of the ACA its provisions supporting full access to high quality, affordable health care, including treatment and recovery –oriented support services for persons living with serious mental illness. In that spirit, NAMI appreciates the opportunity to submit comments related to the health insurance Exchange provisions of the ACA.

NAMI would like to respectfully submit the following overall recommendations regarding implementation of the Exchanges in a way that best meets the needs of individuals living with serious mental illness. Specifically, NAMI recommends inclusion of the following improvements to provisions in the current proposed rule:

- Explicit recognition that the law requires Exchanges to consult with certain groups of stakeholders as they establish their programs and throughout ongoing operations, and the specific requirement that the Exchanges regularly consult with advocates for individuals with living with disabilities and chronic conditions, including mental illness, both as the Exchanges are developed and on an ongoing basis.
- Encouragement for Exchanges to conduct outreach and education activities to promote participation, including outreach and education targeted difficult to serve populations and groups experiencing health disparities, including access related disparities such as those experienced by individuals living with mental illness.
- A requirement that Exchanges establish standards for termination of coverage that requires issuers of QHPs to provide reasonable accommodations to individuals with disabilities, including mental illness.

In addition, NAMI also recommends CMS make the following additions to the proposed regulation to ensure that the specific needs of persons living with serious mental illness are met:

1. Explicitly identify community-based mental health providers (such as CMHCs) licensed or certified by the state as essential community providers.
2. Explicitly recognize and enforce the essential health benefits requirements of the Exchanges, including the requirement that mental health and substance abuse disorder benefits, at parity with medical/surgical benefits, be covered by all QHPs.
3. Develop and enforce network adequacy standards that ensure access to all essential health benefits, including mental health and substance abuse benefits.
4. Enforce strong consumer protections for QHP enrollees to ensure that individuals can easily obtain access to the type, level, and duration of care they need.
5. Ensure that coverage is easily accessible for those eligible to receive coverage through the Exchange, and that the Navigator programs are sufficiently funded and staffed to facilitate the enrollment process for those individuals for whom the process may be more burdensome and those transferring between Medicaid enrollment and the Exchanges.
6. Require Exchanges to conduct strong outreach and education activities, targeted to the public, eligible employers, consumers and service providers to ensure sufficient access to coverage and benefits.
7. Ensure that governing boards and other advisory bodies tasked with developing and administering the Exchanges includes individuals with expertise regarding the needs of people with disabilities (including serious mental illness).
8. Ensure effective enrollment processes that reduce opportunities for enrollment gaps for those who may be uninsured, transferring between private insurance, public health coverage (in particular Medicaid) and/or uninsured status, or transitioning out of the criminal justice system.
9. Encourage development of person-centered healthcare homes to serve individuals with mental health and/or substance use disorders.
10. Establish standards for termination of coverage that require issuers of QHPs to provide reasonable accommodations to individuals with disabilities, including mental illness.

The following includes a more detailed discussion of the above recommendations and NAMI's specific suggestions for how the health insurance Exchanges can be designed in a way that best meets the needs of individuals with mental health and/or substance use disorders.

1. Identify community mental health and substance use disorder organizations licensed or certified by the state as essential community providers.

NAMI strongly urge CMS to include community mental health centers (CMHCs) that are licensed or certified by the state as essential community providers in the final Exchange and QHP regulations.

The proposed rule identifies essential community providers as “health care providers defined in section 340B(a)(4) of the PHS Act; and Providers described in section 1927(c)(1)(D)(i)(IV) of the Act.” These organizations are either operated by a non-profit or a government and provide services to predominantly low-income and medically-underserved populations. The eligible entities defined in the Public Health Service Act include, among

others, federally qualified health centers, community health center grantees, Title X family planning grantees, Ryan White grantees, state-operated AIDS drug purchasing programs, black lung clinics, hemophilia diagnostic treatment centers, Indian Health Service grantees and certain hospitals that treat predominantly low-income individuals. Unfortunately, the PHS does not specifically reference CMHCs or other community-based behavioral health providers.

CMHCs are non-profit or government operated providers that serve predominantly low-income and/or uninsured individuals. They also often receive most or all of their revenue from Medicaid, Medicare, federal block grant funding, or through other federal, state, and local public funding. As noted earlier in these comments, there are several areas in the proposed regulations that specifically identify individuals with mental illness and substance abuse disorders as vulnerable and underserved populations in need of additional attention. CMHCs and other community-based behavioral health providers have a long history of meeting the health needs of these hard-to-serve populations.

Identifying CMHCs as essential community providers is consistent with the intent of both the law and the proposed implementing regulations, and will help to ensure that there is sufficient capacity and scope to meet the needs of individuals with mental illness being served through health plans offered through the Exchanges. In order to ensure access for these most vulnerable individuals, NAMI urges CMS to include community-based mental health agencies such as CMHCs as essential community providers in the final regulation.

2. Explicitly recognize and enforce the essential health benefits requirements of the Exchanges, including the requirement that comprehensive mental health and substance abuse disorder benefits, at parity with medical/surgical benefits, be covered by all plans participating in the Exchanges.

NAMI is extremely pleased that the ACA requires an essential benefits package for all health plans in the individual and small group markets, and that all such plans will be required to cover mental health and substance abuse disorder services, at parity with medical/surgical services, as essential benefits. These important reforms will both improve the health of millions of Americans and their families and save the health care system many millions of dollars.

NAMI would urge CMS to clarify that the essential benefits package is a central component of the Exchanges, and makes enforcement of benefits requirements a priority. In any final regulation, CMS needs to make clear to states and health insurance plans that the ACA requires a sufficient benefit package for mental illness and substance abuse services that includes early intervention, treatment, rehabilitative and recovery-oriented support services, and that limits on benefits be no more restrictive than those allowed under the *Wellstone/Domenici Mental Health Parity and Addiction Equity Act of 2008* and the statute's implementing regulations.

NAMI would also urge CMS to take this opportunity to provide additional clarity with respect to the obligation of ALL health plans offered through the Exchanges to comply with the Wellstone/Domenici parity law. As you know, Section 1311 of the ACA explicitly sets

forth a requirement for application of the federal parity law in the Exchanges. Any final regulation should restate this requirement and make clear that application of the Wellstone-Domenici should be universal across the Exchanges, regardless of whether individuals or small employers are purchasing coverage.

In addition, NAMI asks that CMS and HHS to develop strong enforcement mechanisms to ensure that all QHPs meet the essential health benefits and mental health addiction parity requirements.

3. Develop and enforce network adequacy standards that ensure access to all essential health benefits, including mental health and substance abuse disorder benefits.

The rule proposes that Exchanges make health insurance – and therefore health care – available to a variety of consumers, including those who reside or work in rural or urban areas where it may be challenging to access health care providers, by requiring Exchanges to “ensure that the provider network of each QHP offers a sufficient choice of providers for enrollees.” NAMI strongly supports this goal. The ACA sets a number of standards to ensure that comprehensive plans are offered in the individual and small group markets, including the requirement that plans provide the essential benefits package and meet actuarial value requirements. An inadequate provider network, however, would undermine these requirements.

The ACA further requires the Secretary to establish network adequacy requirements for health insurance issuers seeking certification of QHPs. However, the rule proposes to delegate this responsibility to each Exchange. NAMI believes that the final rule should instead establish national standards that will serve as a minimum level of protection for network adequacy across the country. Such standards can be broad enough to ensure that they are appropriate to each state’s needs. CMS should consider adding provisions to the final regulations that require all QHPs to demonstrate that they have a sufficient choice of providers accepting their health plan to meet the minimum national network adequacy standards.

The proposed rule seeks comment on a potential additional requirement that the Exchange establish specific standards under which QHP issuers would be required to maintain the following: (1) sufficient numbers and types of providers to assure that services are accessible without unreasonable delay; (2) arrangements to ensure a reasonable proximity of participating providers to the residence or workplace of enrollees, including a reasonable proximity and accessibility of providers accepting new patients; (3) an ongoing monitoring process to ensure sufficiency of the network for enrollees; and (4) a process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider is accessible for that benefit in a timely manner. NAMI supports this additional requirement as a baseline for establishing specific standards related to ensuring access and availability of providers.

4. Enforce strong consumer protections for qualified health plan enrollees to ensure that individuals can easily obtain access to the type, level, and duration of care they need, and that confidentiality is protected.

NAMI is pleased that the ACA requires health insurance Exchanges to ensure that participating health plans meet a number of critically important consumer protection requirements. Moving forward, it will be important for the final Exchange regulations to include strong patient and consumer protections, as well as enforcement mechanisms. Specifically, it is important that determinations about who needs what services, levels of care, and lengths of stay be made by treatment professionals that have met with the patient, and medical management tools such as utilization review, criteria for review and approval of evidence-based treatment services, preferred provider networks, and preauthorization be used appropriately and not be used to deny needed care. The medical management criteria and utilization review tools should also be made available in a transparent manner to service providers to ensure patient access to appropriate care. In addition, CMS should consider guidance precluding private insurers from denying claims for criminal justice-involved patients who are otherwise eligible to receive those services.

Exchanges should also enforce strong transparency requirements to ensure that criteria and reasons for denial of care are disclosed and subject to a meaningful, independent review process that includes examination of plan benefit utilization patterns and enables individuals to effectively challenge a denial.

- 5. Ensure that coverage is easily accessible for those eligible to receive coverage through the Exchange, and that the Navigator programs are sufficiently funded and staffed to facilitate the enrollment process for those individuals for whom the process may be more burdensome and those transferring between Medicaid enrollment and the Exchanges.**

The Exchanges should develop strong enrollment facilitation tools and procedures to ensure that all who are eligible to participate in the Exchanges are able to easily access coverage. This is especially important for individuals living with mental illnesses, as they are more likely to experience difficulties navigating a complicated system. In NAMI's view, a robust Navigator program is critically important to ensure effective Exchange outreach and enrollment.

First, CMS needs to ensure that Navigator requirements include training on working with diverse populations with diverse health needs, including people with disabilities such as serious mental illness. Navigators should receive specific training and effort should be taken to ensure that individuals with chronic health conditions, such as mental illness, are connected to health insurance coverage that is appropriate for their needs. Also, while the ACA does prohibit federal funding for the Navigator programs, HHS nonetheless needs to monitor the Navigator programs to ensure that they have sufficient funding to meet the needs of all potential Exchange enrollees.

It is important to note that individuals with untreated mental illness are less likely to have stable, long-term employment and is therefore more likely experience disruptions in their health coverage. Thus CMS needs to ensure effective enrollment processes and a minimum of disruption for those who may be uninsured, transferring between private insurance, public health coverage (in particular Medicaid) and/or uninsurance, or transitioning out of the criminal justice system. Such steps should include: requiring real time, pre-populated

electronic application and redetermination systems; Navigator support and other outreach and enrollment initiatives targeted to those who are most vulnerable, including those transitioning out of the criminal justice system; presumptive eligibility and other expedited or streamlined eligibility processes for those likely to be found eligible; trainings and education for Navigators and eligibility workers; and the establishment of performance metrics to increase enrollment and decrease disenrollment of eligible individuals.

Similarly, the proposed rule seeks comment as to whether CMS should require that at least one of the entities serving as Navigators include a community and consumer-focused non-profit organization. Requiring that at least one of the Navigator entities includes a community and consumer-focused non-profit organization has significant potential to strengthen the Navigator program and help it to better meet the diverse needs of those seeking coverage through the Exchange. CMS should integrate this requirement in the final regulations.

CMS should also consider specific language in the final regulations requiring that states suspend, rather than terminate, Medicaid eligibility for individuals who lose coverage for federal Medicaid payments due to their status as an inmate of a public institution or as a resident in an Institution for Mental Disease (IMD) as defined under federal Medicaid law.

6. Require Exchanges to implement a strong outreach and education effort to ensure sufficient access to coverage and benefits and identification of consumer rights violations.

Successful implementation of the Exchanges will require a strong outreach and education component to ensure eligible individuals, employers, and others understand how to access coverage and services. To maximize the effectiveness of the Exchanges, such broad outreach needs to include: promotion of coverage for individuals, families, and small businesses; targeting to specific hard-to-reach populations; and coordination among various entities, including navigators and other state-based and community assistors.

NAMI appreciates that the preamble of the proposed regulations specifically encourages Exchanges to conduct outreach broadly and to also target specific groups and hard to reach populations, including individuals with mental illnesses and substance use disorders. However, the Exchanges should also be required to conduct outreach and education activities, both broadly and targeted to underserved populations.

In addition, successful implementation of the Exchanges will also require strong outreach and education efforts directed at health providers, including providers of mental health and substance abuse services, to ensure that they understand how to help patients access coverage and care and identify violations of consumer rights.

7. Ensure that governing boards and others tasked with developing and administering the Exchanges include individuals with expertise regarding the unique needs of individuals with disabilities and chronic conditions – including serious mental illness.

NAMI appreciates the invitation to comment on the types of representatives that should be

on Exchange governing boards to ensure that consumer interests are well-represented. The governing boards of each state-based health insurance Exchange, regardless of whether the Exchange is governed by a state agency or a non-profit organization, should include individuals with expertise regarding the unique needs of individuals living with serious mental illness.

Specifically, NAMI recommends that the governing membership of each Exchange include state administrators of publicly funded mental health services. In addition, these state officials should also be consulted in the development and design of the Exchanges in their state. Also, as CMS and the Department move forward with implementation of the federally administered Exchange, it will be important for the appropriate federal agencies and other experts are included in the development and governance of the federal Exchange, including those with expertise regarding the unique needs of individuals with serious mental illness. Specifically, we urge the inclusion of the Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA) on the governing membership of the federally administered Exchange.

8. Ensure effective enrollment processes that reduce opportunities for enrollment gaps for those who may be uninsured, transferring between private insurance, public health coverage (in particular Medicaid) and/or uninsured status, or transitioning out of the criminal justice system.

NAMI commends the ACA requirement for a single streamlined application to ease the application process and increase eligibility coordination between the Exchange, Medicaid, CHIP and other public programs. Individuals affected by mental illness and/or substance use disorders are highly likely to be eligible, but not enrolled in health care coverage, and to experience disruptions in health coverage.

NAMI urges CMS to ensure effective enrollment processes that reduce opportunities for enrollment gaps for those who may be uninsured, transferring between private insurance, public health coverage (in particular Medicaid) and/or uninsured status, or transitioning out of the criminal justice system. In particular, NAMI urges CMS to require the following:

- Real time, pre-populated electronic application and redetermination systems;
- Navigator support and other outreach and enrollment initiatives targeted to those who are most vulnerable, including those transitioning out of the criminal justice system; Presumptive eligibility and other expedited or streamlined eligibility processes for those likely to be found eligible;
- Training and education for Navigators and eligibility workers;
- The establishment of performance metrics to increase enrollment and decrease disenrollment of eligible individuals; and
- Suspension, rather than termination, of Medicaid eligibility for individuals who lose coverage due to their status as an inmate of a public institution or as a resident in an Institution for Mental Disease (IMD).

9. Encourage development of person-centered healthcare homes to serve individuals with mental health and/or substance use disorders.

Bi-directional integration of health, mental health and substance abuse care in person-centered health homes holds the promise of more effectively and cost-efficiently meeting the whole health needs of individuals living with serious chronic or co-morbid conditions. NAMI would encourage CMS to move forward with the development of person-centered healthcare homes to serve individuals with mental health and/or substance use disorders. As part of such an effort, CMS should encourage community mental health agencies to develop care coordination and primary care capacity necessary to serve as health homes for people with serious mental health and/or substance use conditions.

10. Establish standards for termination of coverage that require issuers of QHPs to provide reasonable accommodations to individuals with disabilities, including mental illness.

NAMI is pleased with provisions in these regulations prohibiting QHPs from unfairly dropping or withdrawing coverage for enrollees who get sick. Because of this provision individuals with mental illness will be able to keep coverage when they need it most. When coverage termination is indicated for other reasons, people with mental and/or substance use disorders will need extra assistance navigating procedures to prevent wrongful termination.

CMS should build on this critical protection by establishing standards for termination of coverage that require issuers of QHPs to provide reasonable accommodations to individuals with disabilities, including mental illness. CMS should also consider requiring Navigators and Consumer Assistance Programs to assist consumers facing potential termination in understanding the reason for potential termination and, when appropriate, with filing a timely appeal.

Conclusion

NAMI appreciates the opportunity to provide comments on the establishment of health insurance Exchanges and Qualified Health Plans under the ACA. The Exchanges are central to health insurance reform and, as the key mechanism in the ACA for improving access to affordable, quality coverage, are one of the new law's most important components. Therefore, the ultimate success of reform depends in a large part on the successful development and implementation of the Exchanges. NAMI looks forward to working with CMS on the development of the Exchanges and other critically important provisions of the ACA.

Sincerely,

A handwritten signature in black ink that reads "Michael J. Fitzpatrick". The signature is written in a cursive style with a large, stylized "M" and "F".

Michael J. Fitzpatrick, M.S.W.
Executive Director