September 26, 2011

Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services (HHS)
Attention: CMS–9989–P
P.O. Box 8010
Baltimore, MD 21244–8010

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

Dear Administrator Berwick:

URAC is pleased to submit its comments on the above proposed rule, published in the *Federal Register* on July 15, 2011. Our comments focus on how Exchanges can offer individuals and employers a choice of qualified health plans that inspire their trust and confidence, built upon robust QHP issuer accreditation and QHP certification processes. To be successful, Exchanges must also excel at providing consumer-friendly information on their QHP choices, including cost, quality, and enrollee satisfaction, and ensure the eligibility and enrollment processes are as streamlined and seamless as possible.

As a nationally recognized health care accreditation organization known for our consumer- and quality-first orientation, we believe our comments will be helpful in building Exchanges which meet the Affordable Care Act’s (ACA) goals of offering affordable, easy-to-determine QHP choices which compete on value and performance. URAC has a long history of helping ensure health plan enrollees receive the quality care, rights, and protections to which they are entitled, founding the nation’s first and leading health utilization management accreditation program in 1990. URAC’s programs are recognized by 46 states and the District of Columbia; in addition, URAC has been awarded deeming status by CMS for accreditation of Medicare Advantage plans.

Looking forward to ACA’s requirement for accreditation of QHP issuers, URAC has just released its Exchange-ready Health Plan accreditation program, version 7.0, which addresses all the requirements specified under section 1311(c)(1)(D)(i) of the ACA, including a comprehensive set of performance measures and robust scoring methodology. In addition, our Health Plan version 7.0 accreditation program (see summary of standards attached) is designed with maximum flexibility built-in, allowing incorporation of additional local requirements established by the
individual Exchanges.

Given the enormous task at hand for states in building their Exchanges, URAC applauds the wide range of state flexibility provided by ACA and the proposed rule in terms of developing Exchanges that can be organized at the state level, subsidiary Exchanges within a state, or regionally involving two or more states. Also commendable are the extension of timelines for achieving Exchange planning readiness benchmarks, the offering of conditional approval status for states needing more time to ready their Exchanges for implementation, allowing states to take over an Exchange initially operated by the federal government, and offering the option of CMS partnering with states in building/operating their Exchanges.

Following are URAC comments and recommendations on key areas in the proposed rule that we believe will require CMS’s close attention and/or clarification as it develops its final rule for Exchanges and QHPs.


   a. Assuring a Level Playing Field Inside and Outside the Exchange; Avoiding Adverse Selection Practices.

      Oversight of Marketing Practices (§ 156.225)

One major tenet of the establishment of Exchanges under the ACA is the empowerment of consumer choice, as spelled out in detail under section 1312(d). This provision makes clear that the health plan market outside an Exchange is free to continue to operate, and that qualified individuals and qualified employers are free to choose health plans offered outside the Exchange. In addition, section 1301(a)(1)(C)(iii) signals Congress’s intent that the market inside and outside the Exchange operate on equal footing, requiring that the premium a QHP issuer charges for all of its QHP offerings be identical, whether inside or outside the Exchange.

URAC believes Exchange viability will, in part, depend on assuring a fair and level competitive playing field for health plans operating inside and outside the Exchange. In particular, we believe plans inside and outside the Exchange should be held to the same set of state marketing requirements and oversight, as provided in the proposed rule’s section 156.225, which specifies that QHP issuers are subject to the same state marketing laws and regulations as are imposed on all health insurance issuers. In addition, this proposed rule proscribes QHP issuers from employing discriminatory marketing practices “that discourage the enrollment of individuals with significant health needs in QHPs.”
Thus, the proposed rule is clear that health insurance issuers inside and outside the Exchange must abide by the same state marketing and oversight requirements, and that adverse selection practices by QHP issuers (and its officials, employees, agents and representatives) are strongly discouraged. URAC also supports the proposed rule’s related recommendation to allow an Exchange to take action to address such practices if not otherwise already under the purview of the state department of insurance or other state agency to do so.

A key hallmark of Exchange websites is the provision of comparable and transparent, side-by-side, comparisons of QHP choices in terms of benefit packages, premiums, cost sharing, and performance ratings. URAC’s main concern is that, unless states mandate that non-Exchange issuers display/market their health plan choices and options in identical fashion, they may be able to obtain a competitive advantage over issuers operating on the Exchanges. Such an advantage could potentially lure significant numbers of qualified individuals and employers away from enrolling on the Exchange, which may in turn cut projected QHP enrollee volumes below operationally viable levels.

URAC considers it critical to the ultimate financial success and long term viability of an Exchange to have a balanced demographic spectrum of enrollees served by all of its QHPs, as well as a wide selection and geographic distribution of QHP choices. While in the initial years of operation additional federal support will be offered to Exchanges to permit buffering against undue QHP risk exposure, it is vital that Exchanges guard against having a disproportionate concentration of high risk/high cost individuals end up in a subset of its QHPs. Ultimately, such an imbalance could lead to the financial distress or failure of these unduly burdened QHPs and/or overtax their ability to provide access to needed services in timely fashion.

In the case of regional Exchanges, in order to provide a consistent level of consumer protections across the participating states, it will be very important that the involved states’ departments of insurance cooperate and collaborate closely to achieve such a level of uniformity in oversight and enforcement.

In summary, URAC believes Exchanges offer the opportunity to attain a new industry benchmark for the clear and objective presentation of health plan choices to consumers. Our commitment to this goal is reflected in all of URAC’s accreditation and educational programs. In addition, URAC was an active participant on the National Association of Insurance Commissioners (NAIC) workgroup which provided its guidance to CMS on standardizing consumer coverage and benefit information. This input is reflected in CMS’s recently released proposed rule (and related templates and instructions) entitled “Summary of Benefits and Coverage and Uniform Glossary of Terms” with
which health plans and health plan issuers must comply beginning March 23, 2012 (as required under ACA section 1001, amending section 2715 to the Public Health Service Act). URAC plans to submit comments on this recently released proposed rule and related templates and instructions, which includes a standardized health plan policy comparison tool for consumers.

2. Health Insurance Issuer Standards Under the ACA, Including Standards Related to Exchanges.

QHP Issuer Participation in an Exchange  (§ 156.200 - § 156.270)

Proposed rules § 156.200 - § 156.270 set forth an extensive set of requirements for QHP issuer participation in an Exchange, including obtaining certifications for all of its participating QHPs, complying with all Exchange requirements related to marketing, provision of rate and benefit information, and assuring all its QHPs meet network adequacy standards. Unfortunately, the proposed rule does not make explicit what an Exchange’s responsibility is in assuring that a QHP issuer meets and continues to comply with this long list of requirements. In this vein, URAC would recommend CMS provide a more explicit statement of how an Exchange would go about qualifying a QHP issuer for initial and ongoing Exchange participation (apart from obtaining accreditation, for which an Exchange can set timelines well after QHP certification occurs).

It is clear, however, that an Exchange and its QHP issuers will be interacting at an earlier point in time, as issuers must provide detailed information in order to secure QHP certification. Exchanges will also require QHP issuers to supply information on its QHPs for ongoing monitoring activities, as well as for deciding on QHP recertifications and decertifications.

Given that specific QHP issuer requirements related to quality data reporting, quality improvement strategies, and enrollee satisfaction surveys will be the subject of a future CMS proposed rule, URAC urges CMS expediency in publishing this very important guidance. This will be helpful as URAC prepares to serve as a CMS recognized accreditor for QHP issuers on Exchanges.

Accreditation of QHP Issuers  (§156.275)

As noted in the preamble to this section, “Accreditation acts as a ‘seal of approval’ to indicate to individuals and employers seeking coverage that a health insurance issuer meets minimum standards of quality and consumer protection.” URAC could not agree more, and believes our Exchange-ready Health Plan version 7.0 accreditation program will lend this high level of consumer trust and confidence to issuers receiving this well respected URAC distinction.
Soliciting Comment on Standards by Which CMS Should Recognize Accrediting Entities (p. 41903)

As a nationally respected health care accreditation organization, known as an industry leader in consumer protection, education, and empowerment, URAC is pleased to offer its guidance to CMS on standards for recognizing accrediting entities. Our recommended standards include:

A. Industry Expertise and Accreditation Experience and Widespread Recognition.

- Length of experience and demonstrated success as an accrediting entity.
- Depth of health industry knowledge and awareness and responsiveness to trends and issues specific to health plans and insurers.
- Knowledge, sensitivity, and demonstrated responsiveness to consumer protection, education, and empowerment needs.
- Range and number of accreditation programs that address key QHP issuer functions (URAC has 27 programs, including: health plans, health networks, Medicare Advantage deeming, Patient Centered Health Care Home, case management, consumer education and support, comprehensive wellness, disease management, health utilization management, health website, health call center, HIPAA privacy and security, health plan external review, health plan independent review, and provider performance measurement and public reporting). URAC’s accreditation programs are widely recognized commercially as well as by state and federal governments.

B. Independent, Rigorous, and Publicly Transparent Standards and Measures Development Processes.

- Standards and validated measures are developed by multi-stakeholder, industry-spanning groups of experts, and are submitted to a public review and comment process before being finalized.
- Standards and measures are regularly reviewed for currency, and undergo regular updates as dictated by changing laws, regulations, and industry norms.
- Issuance of full and detailed reports on completed accreditation surveys, including corrective action plans and summaries of findings.
- Strong commitment to transparency, avoidance of conflicts of interest, and public reporting of accreditation results.
- Measures collected as part of the accreditation process are harmonized with measures collected by Exchange for establishment and public reporting of QHP ratings (minimizing measures reporting burden for

- Health plan accreditation process is comprehensive and educational and includes a desk-top review, on-site interviews and examination of health plan policies, procedures, and quality management programs. Accreditation specifically examines a health plan's consumer complaints process, consumer safety mechanisms to prevent harm, conduct of health risk assessments, member enrollment process, management of online directory and member portal information, operation of pharmacy and therapeutics committee, provider credentialing, network management to assure access to health care services, provider dispute process, utilization management (prospective, concurrent, retrospective), adherence to current evidence based care guidelines, and compliance with consumer appeal rights consistent with federal Uniform External Review requirements. Also reviewed are the health plan's compliance with HIPAA Privacy and Security controls for protecting members' personal health information, including verification of staff training and security controls for the health plan's electronic and physical infrastructure.
- Ability to complete in person and desk top accreditation reviews and decisions in timely fashion (flexibility to complete process in a minimum of 6 months to a maximum of 12 months).
- Accreditation awarded by multi-stakeholder committee of industry peers through a blinded impartial review of the applications.
- Post-accreditation ongoing monitoring of health plan performance.
- A complaint investigation program for providers, consumers, and regulators to report concerns to accredditor related to the health plan standards.
- Collaborative approach to working with state regulators to permit generation of state-specific health plan performance reports and participation of state representative in on-site closing conference.
- Failure to comply with accreditation standards can result in establishment of health plan corrective plan and/or revocation of accreditation.
- Issuance of Accreditation Summary Report with transparency of robust scoring methodology and results.

D. Health Plan Accreditation Program Meets All Requirements of Section 1311(c)(D)(i) of the ACA and the Exchange Proposed Rule.
Accreditation program for QHP issuers must address all requirements listed in ACA and the proposed rule (as does URAC’s Exchange-ready Health Plan Accreditation Program, version 7.0).

Expertise in assessing direct primary care medical homes (URAC’s Patient Centered Health Care Home Achievement award is a perfect fit for this requirement, for health plans which utilize medical home networks. In this vein, URAC offers a Health Plan Accreditation with Patient Centered Health Care Home Network Designation). Note: Please also see additional comments below for proposed rule §156.426.

Ability to collect and report clinical quality measures, including any added measures required of individual Exchanges.

Clinical quality measures are aligned with the six National Quality Priorities listed in the March 2011 HHS Report to Congress: “National Strategy for Quality Improvement in Health Care.” (URAC’s Health Plan Accreditation program’s measures include all six national priorities, as well as additional domains critical to successful delivery of high quality care).

Accreditation measures’ reporting burden on health plans is minimized, by utilizing measures which already reside in the public domain, and/or consider use of publicly reported measures where feasible, promoting standardization and reducing “measure fatigue” across the industry. The goal is to harmonize measures utilized for accreditation purposes and those reported to Exchanges for plan performance ratings, to avoid unnecessary duplication of effort and cost.

Transparent and rigorous methodological and scoring criteria (as is provided in URAC’s Health Plan, version 7.0 accreditation program).

In addition to the above, URAC believes accreditation of a QHP issuer should also include assessment of its pharmacy benefit management functionality, including its impact on timely QHP member access to needed medications.

E. Expedited or Grandfathered CMS Approval of Existing Nationally Recognized Private Health Plan Accreditation Programs that Are Already in Wide Use Throughout the Industry.

Nationally recognized private accrediting organizations such as URAC and NCQA have established a strong historical presence, expertise, and credibility in the health plan accreditation marketplace, offering a “Seal of Approval” that carries great weight amongst government regulators, legislators, insurers, providers, and consumers. Given the tight timelines and financial pressures for getting Exchanges up and running, it would make great sense for CMS to grandfather well established
There is already federal precedent for such direct recognition of accreditor competency, as displayed in the “Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act,” published in the Federal Register on July 23, 2010. Specifically, this interim rule allows for state approval “only of Independent Review Organizations that are accredited by a nationally recognized accrediting organization.” The interim rule makes no further specification of “nationally recognized accrediting organization”—federal acceptance for employing such an organization is implicit and direct.

Treatment of Direct Primary Care Medical Homes (§156.426)

URAC strongly supports the proposed rule’s allowing a QHP issuer to provide coverage through a direct primary care medical home “that meets criteria established by CMS, so long as the QHP meets all requirements that are otherwise applicable and the services covered by the direct primary care medical home are coordinated with the QHP issuer.” Comments are solicited on page 41900 of the proposed rule, regarding “what standards CMS should establish under this section.”

In response to this solicitation, URAC is attaching its standards employed for our Patient Centered Health Care Home (PCHCH) Achievement Program. These comprehensively address the key areas of care access, patient engagement and shared decision-making, care coordination, referral networks for specialists and community service resources, quality improvement activities based on patient experience surveys and clinical quality measures, provision of prevention and wellness services, care team support of patient self-management including medication adherence, and compliance with CMS requirements for meaningful use of certified electronic health record technology, including e-prescribing systems.

URAC defines a Patient Centered Health Care Home (PCHCH) as an interdisciplinary clinician led team approach to delivering and coordinating care that puts patients, their families, and caregivers at the center of all decisions concerning the patient’s health and wellness. A PCHCH provides enhanced access to physical health, behavioral health, and supportive community and social services, ensuring patients receive the right care in the right setting at the right time. URAC’s PCHCH program aligns with the “Joint Principles for a Patient-Centered Medical Home” issued by the four primary care medical societies listed in the paragraph below.

As confirmed in a recently released analysis by the Medical Group Management
Association, URAC’s PCHCH Achievement Program also meets all the “Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs,” issued jointly in February of 2011 by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association. These guidelines are presented below as further guidance in helping CMS develop standards for QHP issuer provision of coverage through a direct primary care medical home:

According to the guidelines, “All Patient-Centered Medical Home Recognition or Accreditation Programs should:

1. Incorporate the Joint Principles of the Patient-Centered Medical Home
2. Address the Complete Scope of Primary Care Services
3. Ensure the Incorporation of Patient and Family-Centered Care Emphasizing Engagement of Patients, their Families, and their Caregivers
4. Engage Multiple Stakeholders in the Development and Implementation of the Program
5. Align Standards, Elements, Characteristics, and/or Measures with Meaningful Use Requirements
6. Identify Essential Standards, Elements, and Characteristics
7. Address the Core Concept of Continuous Improvement that is Central to the PCMH Model
8. Allow for Innovative Ideas
9. Provide Care Coordination within the Medical Neighborhood
10. Clearly Identify PCMH Recognition or Accreditation Requirements for Training Programs
11. Ensure Transparency in Program Structure and Scoring
12. Apply Reasonable Documentation/Data Collection Requirements
13. Conduct Evaluations of the Program's Effectiveness and Implement Improvements Over Time”
URAC firmly believes the quality and effectiveness of care provided by QHPs can be greatly fortified by inclusion of direct primary care medical homes/PCHCHs serving as the central care coordination and oversight hub of a QHP. As such, we heartily endorse this provision of the proposed rule, and hope our attached standards are of value to CMS.

3. Exchange Functions: Certification of Qualified Health Plans; Issues Relating to Certification of QHPs and Accreditation of QHP Issuers (§ 155.1000 and seq.; 155.1045)

In terms of participation on an Exchange, the proposed rule makes clear that QHPs must obtain certification by the Exchange, while QHP issuers, in accord with Section 1311(c)(1)(D)(i) of the ACA, “must be accredited with respect to their QHPs.” While QHPs must first obtain certification prior to being listed on an Exchange, the ACA and the proposed rule allow Exchanges “to establish the time period within which any QHP issuer that is not already accredited must become accredited following certification of a QHP.”

The proposed rule recognizes the fact that accreditation of QHP issuers may require a grace period of 18 months or longer after a QHP has become certified, particularly for those issuers seeking a first-time accreditation. Exchanges are given discretion in setting a consistent deadline for a QHP issuer to obtain accreditation after its QHP(s) have received certification, which would be applicable to all QHPs on an Exchange, and which would accommodate the length of the accreditation process. One goal of giving Exchanges this flexibility is to “allow for inclusion of a wider variety of QHP issuers in the Exchange.” Based on our experience in performing health plan accreditations, URAC recommends a maximum grace period of 36 months to achieve full accreditation, and that a QHP issuer be required to demonstrate sufficient progress towards this goal by being awarded provisional accreditation status within 12 months of initiating the accreditation process.

URAC believes the above proposed rule provisions are vital for getting Exchanges up and running with a wide choice of QHPs. Since Exchanges are responsible for assuring QHPs are certified according to the standards specified in the proposed rule, the ability to obtain contractual assistance in performing this function from an “eligible entity,” as permitted under the ACA, could be expeditious for meeting Exchange implementation deadlines. The ACA and proposed rule specify that “an eligible entity is one that: (1) Is incorporated under and subject to the laws of one or more states; (2) Has demonstrated experience on a state or regional basis in the individual and small group markets and in benefits coverage, and; (3) Is not a health insurance issuer or treated as a health insurance issuer. An eligible entity also includes the state Medicaid agency.”
Given the fact that Exchanges will be charged with performing a daunting array of technically challenging tasks in a short amount of time, we believe it is important they be able to obtain the expert counsel of broad range of entities.

Ensuring Adequate and Stable QHP Participation and Enrollment Capacity on the Individual and SHOP Exchanges

To be successful and competitive with the non-Exchange market, Exchanges must be able to attract and maintain a sufficient number of QHPs and enrollees. This is critical to an Exchange achieving financial self-sufficiency (through collection of QHP issuer assessments or user fees as required by Section 1311(d)(5)(A)), and also having sufficient capacity for all individuals and small businesses choosing to enroll in a QHP offered on the Exchange.

Keeping QHP availability and enrollee capacity at acceptable and stable levels will require that Exchanges plan for contingencies to avert, or minimize the impact of, QHP issuer non-participation, as well as QHP Exchange withdrawals and/or decertifications. To minimize the impact of such events on Exchange viability, URAC recommends that CMS require each Exchange to formalize policies and procedures that address the following scenarios:

a. Inadequate initial QHP issuer participation on either the individual or SHOP Exchanges. One possible solution would be to delay the Exchange implementation date (an option CMS has recently signaled it is considering). Another would be for the Exchange to assist enrollment in non-Exchange plans while additional Exchange QHP capacity is built, allowing migration to the Exchange when new capacity becomes available (with the understanding that recapturing individuals and employers driven to non-Exchange plans may be difficult).

b. Allowing orderly transition from a discontinued Exchange QHP to another Exchange QHP choice in orderly fashion (assuming sufficient capacity exists in the receiving Exchange QHPs; otherwise assisting in redirecting enrollees to non-Exchange QHP offerings).

c. The potential lag time between QHP certification and QHP issuer accreditation creates a number of possible scenarios for which Exchanges should have formalized policies and procedures:

1. QHP issuer does not receive accreditation by the Exchange ordained timeline. The Exchange should be prepared to decertify the issuer's QHPs before the next open enrollment period and aid transitioning enrollees to other QHP offerings.
2. To avoid the situation in 1. above, URAC would recommend that CMS and Exchanges be permitted to accept a provisional accreditation status when not all required accreditation standards are met, allowing the organization in question to fulfill the incomplete standards at a later date in time. Granting of provisional accreditation status is already a common practice in the industry, and would help stabilize QHP choices offered on Exchanges.

3. Timing issues—the proposed rule allows Exchanges to determine the cycle for recertification decisions. Given the fact that QHP issuer accreditations are generally granted for a period of three years at a time, it is conceivable that a current accreditation would expire and not be renewed in time to cover the Exchange’s QHP recertification cycle. URAC recommends that CMS require Exchanges to establish policies and procedures which allow grace periods to avert such a potentially destabilizing event.

4. Need to stagger QHP issuer accreditations. Given the fact that one QHP issuer could hold a number of QHPs on a given Exchange, the risk does exist that one or more issuers could undergo the accreditation process and fail. This could potentially lead to decertification of a significant number of QHPs on any Exchange where the issuer operates, reducing the number of QHP choices and the competitive forces on the remaining QHP issuers/QHPs. URAC recommends that CMS require Exchanges to have contingency procedures in place to either (a) give QHP issuers additional time to achieve accreditation (e.g., allow for provisional status as recommended above); or (b) allow for an Exchange to intentionally stagger QHP issuer accreditations, to ensure that QHP availability is stable and predictable.

5. URAC also believes CMS should require Exchanges to permit an already accredited QHP issuer to implement an accreditor issued corrective action plan when monitoring by the accreditor indicates not all accreditation standards are being met. This policy will help ensure ongoing vigilance over consumer rights and protections, while QHP issuer participation on an Exchange is kept stable and predictable.
4. Stand-Alone Dental Plans (§ 155.1065)

URAC supports the ACA and proposed rule requirement that allows an Exchange to include limited scope stand-alone dental plans which must, as a minimum, furnish the pediatric essential dental benefit required under section 1302(b)(1)(J) of the ACA. We believe this provision of the law helps to ensure that there is adequate access to dental services for enrollees and employers participating on an Exchange. In addition, it may also make it easier for more QHPs to participate, since Sec. 1301(b)(4)(F) of the ACA “allows a health plan to be certified as a QHP if it does not offer the pediatric essential dental benefit provided that a stand-alone dental plan is offered through the Exchange.”

URAC also supports the CMS interpretation discussed on page 41894 of the proposed rule “that an Exchange may require issuers of stand-alone dental plans to comply with any QHP certification requirements and consumer protections that the Exchange determines to be relevant and necessary.” CMS asks for comment as to “whether some of the requirements on QHP issuers should also apply to stand-alone dental plans as a Federal minimum…” URAC believes it is in the best interest of an Exchange and its enrolled individuals and employers to apply the same requirements and safeguards to stand-alone dental plans as QHP issuers, including the requirement for obtaining accreditation. Dental plan accreditation is not a novel concept, and is now required by the state of Florida.

5. Exchange Establishment of Network Adequacy Standards (§ 155.1050) and Evaluation of Service Area of a QHP (§ 155.1055)

Assuring timely enrollee access to a comprehensive network of providers and services is critical to the successful operation of an Exchange. URAC agrees with CMS’s statement that network adequacy standards should be flexible to reflect a state’s “particular geography, demographics, local patterns of care, and market conditions.” To allow this flexibility, CMS acknowledges the proposed standard is very broad: “An Exchange must ensure that the provider network of each QHP offers a sufficient choice of providers for enrollees.”

CMS, on page 41894 of the proposed rule, indicates it has considered a number of widely used industry standards for determining network adequacy. CMS notes it seeks to “develop a standard that balances the need for a uniform level of protection with the level of variation across states and local markets.” CMS then provides a set of four proposed baseline standards related to network adequacy which it would require Exchanges to apply to QHP issuers, which are in part based on the NAIC Managed Care Plan Network Adequacy Model Act. The proposed rule also solicits “comment on additional minimum qualitative or quantitative standards for the Exchange to use in evaluating whether the QHP provider networks provide sufficient access to care.”
URAC also supports the proposed rule’s requirements regarding Exchange responsibility for evaluating the service area of QHPs. This is extremely important when looking at access to QHP services on an area-by-area geographic basis for all QHPs on the Exchange, to help discourage QHP issuers from avoiding operating in areas with higher risk/higher cost patients. In addition, an Exchange should try to avert or minimize other access retarding factors, such as average travel time to reach a QHP primary care and other providers, and average wait times for scheduling routine and higher urgency specialist referrals and diagnostic tests.

URAC’s Health Plan and Health Network Accreditation programs include network adequacy standards that require health plans to engage in specific activities to ensure network access and availability. These activities include defining the scope of health care services and geographic area served by a provider network as well as measuring performance against network adequacy goals. In addition, URAC’s standards require provision of access to out of network providers when covered services are not available in-house, as well as round the clock assistance for consumers and providers to address urgent situations. All of these requirements directly support implementation of the baseline standards and geographic service area evaluation proposed by CMS in the proposed rule.

URAC is pleased that CMS, on page 41894, is alerting Exchanges to the initial surge in demand for primary care office visits that is likely to occur concomitant with Exchange implementation—in an environment in which many communities already face serious primary care shortages. While network adequacy for primary care services may meet Exchange requirements under normal circumstances, it is important for Exchanges and QHPs to be ready to handle this expected initial high demand from millions of previously uninsured individuals, many of whom may not have seen a physician for years.

URAC also supports CMS’s concluding remark on the same page, encouraging “States, Exchanges and health insurance issuers to consider broadly defining the types of providers that furnish primary care services (e.g., nurse practitioners).” This inclusion of a wider range of primary care providers, permitted through state scope of practice requirements, is embraced by URAC, and a specific feature of our PCHCH Achievement program, which provides for care teams that include non-physician primary care practitioners.


The proposed rule indicates that Exchanges “apply appropriate security and privacy protections when collecting, using, disclosing or disposing of personally identifiable information it collects. In addition, we propose to require contractual terms that impose these standards on contractors or subcontractors that fulfill Exchange functions or access information from or on behalf of the Exchange.” In
general, the proposed rule suggests that an Exchange apply the privacy and security standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as well as specific privacy and security standards found in the ACA under sections 1411(g), 1413(c)(2), and 1414(a)(1), which apply to some, but not all, types of information flowing to and from the Exchange.

It is understood that the specific design of each Exchange will dictate the specific privacy and security standards which are applicable, based on analysis of its operations and functions relative to federal definitions of “HIPAA covered entities” (health plans, health care clearinghouses and health care providers that conduct certain electronic transactions covered by HIPAA), or “business associates of HIPAA covered entities.” In cases where an Exchange is comprised of HIPAA covered entities and business associates of these entities, HIPAA privacy and security requirements will be applicable.

As an organizational accrreditor of compliance with HIPAA Privacy and Security requirements, URAC believes protection of personally identifiable health information is critical to enrollees’ trust and peace of mind, as well as helping ensure they receive timely and appropriate care, by unfettered sharing of this information amongst providers.

As such, in the request for comment on page 41880 of the proposed rule, URAC supports adoption of the HIPAA privacy model for Exchanges. We also support the Exchange “Use and Disclosure” requirements as proposed under paragraph (b) of §155.260.

Closing Remarks

URAC fully supports the efforts of CMS and the states to build healthy, self sufficient Exchanges that offer a wide array of affordable health plan choices, which make the eligibility and enrollment processes simple and trouble free, and which garner the trust and support of consumers and employers. Making sure Exchanges can compete fairly with the non-Exchange market, are tailored to local stakeholder needs, and keep consumer protections in highest regard, are all essential ingredients in bringing ACA’s vision for Exchanges to life.

URAC hopes our foregoing comments and related attachments are helpful to CMS as it moves forward in crafting a final Exchange rule. We also hope our health plan accreditation expertise will be called upon to lend the credibility and “seal of approval” consumers and employers look to in making informed health plan choices. URAC’s goal is to be part of the solution in building robust Exchanges, and we look forward to providing our guidance and expertise on CMS’s forthcoming Exchange related rules.
Sincerely,

Alan P. Spielman
President and CEO

Attachments:

(1) Health Plan Accreditation Standards, version 7.0
(2) Patient Centered Health Care Home Achievement Program Standards