NATIONAL ASSOCIATION OF Community Health Centers

November 12, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9888-P
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program (CMS-9888-P)

Dear Administrator Brooks-LaSure:

The National Association of Community Health Centers (NACHC) is the leading national membership organization dedicated to promoting Federally Qualified Health Centers (also known as FQHCs or Community Health Centers) as the Employer, Provider, and Partner of choice in all communities, as well as the foundation of an equitable health care system, free from disparities.

Community Health Centers are the best, most diverse, most innovative, and most resilient part of our nation's health system. For nearly sixty years, health centers have provided high-quality, comprehensive, affordable primary and preventive care, dental, behavioral health, pharmacy, vision, and other essential health services to America's most vulnerable, medically underserved patients in urban, rural, suburban, frontier, and island communities. Today, health centers serve nearly 32.5 million patients, or 1 in 10 individuals, at over 16,000 locations. This includes nearly 10 million or 1 in 7 rural residents, more than 29 million or 1 in 3 in poverty, and more than 5 million or 1 in 5 uninsured people.

In addition to medical services, health centers provide dental, behavioral health, pharmacy services, and other "enabling" or support services that facilitate access to care for individuals and families in medically underserved communities, regardless of insurance status or ability to pay. NACHC maintains its role as the national voice for health centers and believes that high-quality primary health care is essential in creating healthy communities. The collective mission and mandate of NACHC and the 1,496 health centers nationwide is to close the primary care gap and provide access to high-quality, cost-effective primary and preventative medical care.

Health centers serve a critical role in the success of Marketplaces in every state. They serve as the medical home for millions of Americans eligible for reduced-cost coverage through Federal and State marketplaces. Twenty percent of health center patients have private insurance, and 50% have Medicaid coverage, some of whom receive coverage through Medicaid expansion.[1]

[1] 2023 UDS HRSA Health Center Program Data

These individuals are frequently eligible for Marketplace coverage, including Advanced Premium Tax Credits (APTCs) and cost-sharing reductions. Additionally, health centers are a vital source of outreach and enrollment (O&E) assistance nationally. With support from the Health Resources and Services Administration (HRSA), and often from CMS programs, health centers helped over 4.5 million individuals seeking coverage in 2023.[2] This assistance includes assisting individuals to enroll in Medicaid, CHIP, Medicare, or the Marketplace; it also includes helping individuals with re-enrollments, renewals, or redeterminations, as well as understanding and utilizing their newly acquired insurance.

NACHC welcomes the opportunity to comment on the 2026 Notice of Benefit and Payment Parameters. Our comments are broken into two sections: I. Enrollee Protections and Oversight and II. Health Exchange Standards and Advancing Health Equity through Essential Community Providers.

I. Enrollee Protections and Oversight

NACHC supports CMS increasing oversight at § 155.220 by holding lead agents of insurance agencies accountable for non-compliance or misconduct when enrolling individuals on Federal and State Exchanges. Currently, CMS's oversight actions only extend to individual brokers, and these changes will allow the agency to act officially against non-compliant behavior at the agency level. We appreciate CMS' recent system changes to prevent unauthorized activity on enrollees' Marketplace accounts.[3] These proposals will help ensure the entire entity is held accountable in the case of patterns of non-compliant behavior and support enrollees' ability to work with honest agencies.

Many health center patients possess characteristics that correlate to lower health literacy; for instance, patients with lower incomes, chronic conditions, and those who are non-native English speakers are associated with lower health literacy.[4] Our Primary Care Associations (PCAs) in Florida and Nebraska have reported that brokers are calling health center patients with Limited English Proficiency (LEP) to try and sell them Marketplace plans. Even when the patient is already enrolled in one plan, they often get a call from another broker urging them to enroll in another. People with LEP, especially enrollees who may be new in the Marketplace in general, are particularly at risk of being unable to give fully informed consent, especially if the broker/agent does not adequately explain the product they are selling. If a patient with an existing Marketplace plan gets swayed to move to another plan constantly, this could negatively impact their care continuity because their regular doctors are suddenly outside their network. Health center patients, a vulnerable population, can be unfairly taken advantage of by these commission-based agents. A pattern of unethical business practices can wreak havoc on patients' access to quality, affordable health coverage, and these businesses need to be held accountable. NACHC also appreciates that penalties include suspension or termination of the agent's, broker's, or web-broker's Exchange

[2] https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=ODE&year=2022
[3] https://www.cms.gov/newsroom/press-releases/cms-statement-system-changes-stop-unauthorized-agent-and-broker-marketplace-activity
[4] https://pmc.ncbi.nlm.nih.gov/articles/PMC6391993/#:~:text=Low%20health%20literacy%20is%20associated,are%20non%2Dnative%20English%20speakers.&text=Approximately%2080%20million%20adults%20in,limited%20or%20low%20health%20literacy.

Agreements for the current plan year and civil monetary penalties. Since brokers and agents are commission-based, unlike Navigators trained to provide unbiased opinions, we appreciate the intense oversight and enforcement actions CMS will have to hold brokers and lead agencies to the highest standards. NACHC seeks to ensure that all eligible patients receive non-biased, comprehensive enrollment assistance, and it's essential that CMS holds all brokers and lead agencies accountable.

Here are two critical instances that illustrate the importance of tackling this issue:

1) A Federally Qualified Health Center and certified Primary Care Medical Home in Ohio has noticed an alarming number of fraudulent enrollment cases among its patients for the past year. This health center served more than 14,400 patients with 73,330 visits in 2022. Since Marketplace Open Enrollment in 2023, it has identified more than 200 patients who have been impacted by being enrolled in unauthorized plans despite already having Medicaid coverage.

   The health center, trying to cancel these fraudulent plans for their patients, has navigated a slow and cumbersome process. To date, they have only successfully canceled approximately 50 to 60 plans. The health center impresses upon the patient the importance of this issue and has the patient file the fraud claim with the Marketplace, the state's insurance commission, and any other agencies tracking fraud and abuse claims. Many of these fraudulent plans have been in place for months, and therefore, when the fraud claim is submitted, it must be reviewed back to when the plan started, often 45 to 60 days. In the meantime, the health center cannot bill Medicaid for any of the patient's visits until the patient's Medicaid coverage is backdated.

   Additionally, suppose the patient had any healthcare encounters when they had both Medicaid and Marketplace coverage. In that case, the health center cannot bill Medicaid until the Marketplace plan is removed. This lengthy process is delaying providers, especially safety net providers, from billing timely. Sometimes, when the plans have been canceled, another agent steps in and re-enrolls that patient, and the process begins again.

   Being enrolled in an unauthorized plan places immense stress on patients as well. Not only does it bring unease and stress that they were enrolled in a plan without their knowledge, but canceling their plan is also time-consuming. The patients themselves must be the one to call the Marketplace to cancel their plan.[5] Health center patients are lower-income and may be working multiple jobs to make ends meet, proving difficult to carve out the time to be on hold with the Marketplace call center to cancel their plan.

2) A Federally Qualified Health Center in Indiana, which serves over 8,500 patients and provided over 25,000 visits in its service area in 2023, has encountered many instances of brokers potentially taking advantage of patients and providing inaccurate or misleading information to their benefit. They have noticed that consumers have a Marketplace plan, but it remains unclear how those patients were enrolled, as they qualified for Indiana's Medicaid program. Many of their patients shared that they received phone calls, and the

[5] https://www.healthcare.gov/how-to-cancel-a-marketplace-plan/

suspicious agent/broker knew about the patient's insurance situation. In other instances, some of the health center's patients are unaware that their coverage switched from Medicaid to a Marketplace plan until they arrive at the health center for an appointment. The health center then must allocate additional time and resources to help the patient understand the fraud and ensure the patient gets enrolled in the appropriate coverage.

Enrollment in multiple plans puts significant financial stress on the patient and the health center. When a patient comes in for an appointment, it becomes a battle of which insurance will pay for the visit. Often, health centers find it difficult to reconcile, and neither insurance thinks they should pay; the Marketplace says the patient has Medicaid coverage, and then Medicaid says the patient has Marketplace coverage. Health centers operate on slim financial margins and have faced significant challenges due to Medicaid unwinding. Health centers serve anyone regardless of their ability to pay and depend on getting paid on time. Having patients enrolled in multiple insurances, through no fault of their own, leads to delayed payment and additional financial strains on the health center.

NACHC urges CMS to continue looking into marketing ploys broker agencies post on social media. We have heard anecdotally from state PCAs that many patients discover these Marketplace plans via social media such as Facebook or YouTube ads. These Facebook ads or YouTube videos entice consumers by stating they will get money back on their taxes if they enroll in Marketplace plans. We appreciate CMS publishing best practices for Marketplace Advertising and Marketing Guidelines to clearly outline what is and what is not allowed.[6] However, if CMS could take a stronger stance by prohibiting certain marketing tactics, as it did in a final April 2023 rule with Medicare Advantage plans,[7] This could save enrollees time and money, as well as the health centers that are helping rectify situations where enrollees unknowingly sign up for these plans. CMS could include this in its plan as it continues to investigate agencies engaged in murky enrollment practices; if not, we urge CMS to include marketing within the scope of its investigation.

NACHC supports updating language in the Model Consent Form and recommends CMS also add language at § 155.220(j)(2)(ii) to require brokers, agents, and web brokers to use it to obtain and document consumer consent. A resounding commonality between all the consumers was their little understanding of health insurance. The problem could stem from a broker contacting a consumer who does not fully understand the Marketplace. Then, unlike health center O&E staff, they do not fully explain it, but they still enroll the consumer with their inadequately informed consent. As previously mentioned, there are instances where people are getting enrolled in plans unscrupulously. However, there are also instances where unintended enrollments could result from low health insurance literacy and a lack of education on the broker's part to the consumer. We have heard from health centers who have had many consumers tell outreach and enrollment staff in the past year that they were unaware they had an active Marketplace plan.

Requiring brokers, agents, and web brokers to use language within the Model Consent Form could help address this issue and ensure consumers are properly informed before they consent to enroll

[6] https://www.cms.gov/files/document/agent-and-broker-advertising-and-marketing-tip-sheet.pdf
[7] https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program

in a Marketplace plan. Furthermore, since the enrollees are giving consent over the phone or via audio, we have heard instances where State Insurance Commissions investigating unscrupulous enrollment practices have difficulty pursuing a case, given that the enrollee technically gave consent to be enrolled in a plan. However, the key is *informed consent.* Requiring brokers, agents, and web brokers to use language within the Model Consent Form would help enrollees better understand what they agree to.

NACHC supports CMS' proposal to amend § 155.305(f)(4) to require Exchanges to notify consumers and tax filers who have failed to file and reconcile their APTC for two consecutive years. Following the COVID-19 public health emergency, this policy gives the enrollee a chance to properly document their APTCs on their taxes to remain eligible for APTCs the following year if applicable. Furthermore, the Inflation Reduction Act and American Rescue Plan Act extended APTCs (2021-2022 and 2023-2025, respectively)[8] to new populations who may be unfamiliar with the reconciliation process on their taxes at the end of the year. In 2022, many people waited until the last minute to file their taxes, with 21% of respondents stating "general confusion" around all the different tax credits.[9] Additionally, a survey of 2,700 people aged 18 or above found that 61% lacked the basic knowledge related to filing taxes.[10] With the median U.S. household income reported at $80,610 in 2023, having access to APTCs can be crucial to afford comprehensive coverage. NACHC appreciates the Administration continuing to build upon its policies to leverage Marketplace communications to help prevent enrollees from losing financial assistance due to misunderstandings or miscommunications.

NACHC supports revising § 155.400(g) to grant issuers flexibility to help avoid terminating coverage when enrollees underpay premiums by a certain amount and urge CMS to allow this to apply to binder payments. Currently, issuers can use a percentage-based premium threshold to avoid triggering a grace period for non-payment, allowing enrollees to keep coverage while not paying their premium in full. Health center patients are disproportionately financially strained compared to other patients; 61% are low-income (below 200% of the Federal Poverty Level). This proposal will grant leniency to an economically vulnerable patient population. While we think this flexibility will greatly enhance coverage continuity for our patients, we request CMS allow insurers to apply this methodology to a patient's first premium payment, or binder payment, as well. Most recent data show that nearly a quarter of Americans live paycheck to paycheck.[11] Insurance issuers should be granted the flexibility to meet enrollees where they are, regardless of the payment the enrollee is attempting to pay for their health insurance.

NACHC supports revisions to § 155.505(b) to allow application filers to file appeals on behalf of applicants and enrollees on the application filer's Exchange application. Health center O&E staff are savvy at navigating through Healthcare.gov and are experienced in dealing with appeals. Health center patients already deal with significant social drivers of health that impact their everyday lives, and any way to alleviate their burden when it comes to appealing an eligibility determination on the Marketplace will help ease their worry. Because this type of appeal could

[8] https://www.cms.gov/marketplace/technical-assistance-resources/aptc-csr-basics.pdf
[9] https://www.cbsnews.com/newyork/news/expert-confusion-reigns-supreme-as-americans-wait-until-the-last-minute-to-file-their-tax-returns/
[10] https://taxfoundation.org/blog/national-tax-literacy-poll-education/
[11] https://www.cbsnews.com/news/paycheck-to-paycheck-definition/

restore QHP coverage and/or grant additional financial assistance, any provision that decreases enrollee burden and decreases general administrative burden will help hasten the appeal process, ultimately benefiting patients regardless of the appeal outcome.

II. Health Exchange Standards and Advancing Health Equity through Essential Community Providers

NACHC supports CMS' proposal for user fees – 2.5% for FFE and 2.0% for SBE-FP- unless APTC subsidies are extended, which would trigger a decrease in the user fees. Understanding the current uncertainty around APTC subsidies, we appreciate CMS' continued investment in ensuring a stable and strong user fee. The marketplace user fee — a fixed percentage of premium revenue paid by insurers — supports critical functions, including operating and improving the HealthCare.gov website, the Marketplace call center, the Navigator program, consumer outreach, and advertising. HealthCare.gov, the Marketplace call center, and these consumer-facing functions are critical for health centers across the country because they ultimately impact patient outcomes; more funding leads to a strengthened outreach and enrollment workforce providing services that help increase enrollment in health insurance.

Health centers have utilized marketing and outreach funding under the ACA by incorporating Community Health Workers (CHWs) into their patient care teams. CHWs and enrollment assisters are public health workers who are trusted members of or are closely connected to a community. They provide unbiased enrollment assistance and facilitate access to services that improve the quality of care for patients. Unlike CHWs and enrollment assisters funded by the user fees, private navigators and assisters are often paid commissions by a third party. This third party incentivizes private navigators and assisters to direct consumers to certain private products rather than promoting consumer utilization in a neutral manner. Given that user fees fund these core marketplace functions, we appreciate maintaining user fees to allow consumers to access accurate and comprehensive eligibility information for Medicaid and related programs associated with HealthCare.gov.

We appreciate CMS' continued investment in O&E. Awarding $100 million in grants to 44 Navigator organizations nationwide, as part of $500 million in grants for the next five years, will help ensure stability for years to come. We know that from 2016 to 2019, when outreach and enrollment experienced significant budget cuts, unsubsidized enrollment decreased by 2.8 million people.[12] This multi-year commitment will reduce the burden on the safety net and generally ensure better public health because having health insurance is associated with increased access to health services and better health monitoring.[13,14, 15] Health centers will continue playing a crucial

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[12] https://www.cms.gov/newsroom/press-releases/unsubsidized-enrollment-individual-market-dropped-45-percent-2016-2019-0

[13] Baicker, K., Taubman, S. L., Allen, H. L., Bernstein, M., Gruber, J. H., Newhouse, J. P., ... & Finkelstein, A. N. (2013). The Oregon experiment — effects of Medicaid on clinical outcomes. New England Journal of Medicine, 368(18), 1713–1722.

[14] McWilliams, J. M., Zaslavsky, A. M., Meara, E., & Ayanian, J. Z. (2003). Impact of Medicare coverage on basic clinical services for previously uninsured adults. JAMA, 290(6), 757–764.

[15] Buchmueller, T. C., Grumbach, K., Kronick, R., & Kahn, J. G. (2005). Book review: The effect of health insurance on medical care utilization and implications for insurance expansion: A review of the literature. Medical Care Research and Review, 62(1), 3–30.

role in helping enrollees understand their new coverage, and adequate funding will help bolster the workforce.

NACHC supports amending § 156.201 to require issuers offering multiple standardized plan options within the same product network type, metal level, and service area to meaningfully differentiate plans. When seeking health insurance coverage, it can be confusing and overwhelming for individuals to understand and ultimately choose from all the different plan options presented on the Exchange. For instance, in 2019, the number of plans shown to the average marketplace consumer has grown from 25.9 to 113.6 in 2023.[16] Some studies have shown that too many plan choices—such as over 30—can lead to poor enrollment decisions because they confuse and overwhelm the enrollee.[17] Many plans can look identical. Still, elements such as benefits, provider networks, and/or formularies can help enrollees better discern key differences. We appreciate CMS continuing to strive to streamline and overall simplify the selection process for enrollees. This will help simplify the process for any assisters or navigators who are helping consumers browse their options as well.

NACHC also supports amending § 156.202(b) and (d) to clarify that non-standardized plans can vary whether they include adult dental benefit coverage, pediatric dental benefit coverage, and/or adult vision benefit coverage categories. This proposal further clarifies the finalized provisions of the CY25 Notice of Benefit and Payment Parameters. We appreciate CMS removing the regulatory barrier within that final rule to allow states to include adult dental services as an Essential Health Benefit, effective January 1, 2027. Health centers serve as a point of care for over 32 million patients annually, many of whom are uninsured and living in poverty. Although 81% of community health centers provided on-site dental services in 2017, a 30% increase since 2010, low-income adults are still twice as likely to experience tooth decay and gum disease and have unmet oral health needs.[18]

NACHC strongly supports the proposal at § 156.235 to conduct Essential Community Provider certification reviews of plans beginning in Plan Year (PY2026) for FFM states. Health centers are the single largest source of primary care in medically underserved areas and for medically underserved populations. They provide all the necessary health care and wraparound services to help ensure their patients can live healthier lives and increase their overall well-being. Congress designed the Essential Community Providers (ECP) provision of the Affordable Care Act (ACA)[19] to ensure that consumers purchasing coverage on the Marketplace have guaranteed access to trusted providers, which include entities such as community health centers, HIV/AIDS clinics, and family planning health centers. We appreciate the Department's desire to monitor QHP compliance with the federal ECP standard and partner with state-based Marketplaces to ensure that plans, including managed care plans, across the nation meet the ECP participation standard. Stronger oversight will ensure that families have adequate access to affordable, quality care provided by health centers within their communities.

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[16] https://www.shvs.org/the-proposed-2024-notice-of-benefit-payment-parameters-implications-for-states/

[17] Rose Chu et.al., "Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces, ASPE Office of Health Policy Issue Brief, December 28, 2021.

[18] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2784602

[19] Section 1311(c)(1)(C)

We ask CMS to provide clear details on how it plans to respond and correct any ECP non-compliance found by plans. NACHC understands that this data is key in ensuring compliance with the ECP standards but believes the agency could go further by outlining how to enforce these standards. For instance, CMS could ask the plan to create a remedy plan, similar to how the final proposal for Medicaid plans to meet network adequacy appointment wait time standards.

As an additional mechanism to ensure that insurers are contracting with health centers, NACHC recommends CMS enforce the "any willing provider" statutory provision for QHPs to contract with ECPs. Section 1311 of the ACA states that QHPs "shall... include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals." As NACHC has stated in previous comments, this language clearly requires QHP issuers to offer good-faith contracts to all ECPs, as defined in the statute, located in their service areas. NACHC recommends CMS enforce this requirement given the statutory language. Currently, CMS mandates that QHPs on FFMs must "offer contracts in good faith to at least one ECP in each ECP category in each county in the service area to participate in the plan's provider network for the respective QHP certification plan year, where an ECP in that category is available…"[20] but given the crucial role health centers play in delivering primary care services, NACHC believes that these good-faith contracts should extend to all health centers in their service area.

NACHC recommends CMS enforce this statutory provision of good-faith contracts, which will better ensure health centers are being reimbursed at least their PPS rate from QHPs and managed care plans. We support and appreciate CMS' proposal to analyze and ensure that QHPs are contracting with an adequate number of ECPs. For context, QHPs are required to pay health centers their Medicaid PPS rate[21] unless they have agreed on an in-network, contracted payment rate, which may or may not be equal to the Medicaid rate. For the purposes of Medicaid, this is a comprehensive, bundled, per-visit rate based on the historical costs of Medicaid services in 1999 and 2000. Receiving PPS is central to the successful relationship between health centers and their patients and its continued financial viability.

Overarchingly, health centers lack adequate resources, staffing capacity, and overall negotiating power to enter fair QHP contracts that sufficiently reimburse them. Despite the ECP provision that mandates QHPs contract with at least 35% of ECP providers in their area, health centers lack the overall bargaining power to come to a fair reimbursement for services provided. Health centers strive to contract with as many insurance providers as possible to ensure they can continue serving their patients regardless of insurance status or insurance type. NACHC has collected examples of issues health centers have recently encountered in ensuring they are getting paid at least the Medicaid PPS rate.

In Oregon, one health center in 2023 raised concerns about the need for QHPs to reimburse at a higher rate than the current rate, which is not at least Medicaid PPS. The PCA has worked closely with the State's Department of Consumer and Business Services (DCBS) to rectify this issue. While they both agree that the ACA does require QHPs to pay health centers at least their Medicaid PPS rate, DCBS does not believe they have the authority to enforce this federal statute because:

[20] https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy
[21] Section 1902(bb) of the Social Security Act

a) CMS has delegated enforcement authority to state insurance commissioners to establish state laws codifying the federal requirements, and

b) Their state legislature did not enact a payment protection provision at the state level when codifying established ACA requirements. They believe the state legislature must officially enshrine it into state law to grant them authority. Absent this action, there is no enforcement mechanism at the state level.

Pennsylvania is another example of health centers struggling with payment adequacy. The State PCA has been helping at least one health center that is not receiving the Medicaid PPS rate from a Managed Care Organization (MCO). When the State PCA brought to their attention the Medicaid PPS payment requirement by the ACA, the MCO stated they had a different interpretation and were not required to pay Marketplace plans the per visit rate.

NACHC recommends CMS create a tracking system to ensure health centers are reimbursed properly by the QHPs or managed care plans they contract with. There is no official tracking mechanism for stakeholders like NACHC to engage with states and hold them accountable. If maintained by CMS and accessible to health center and their state PCAs across the country, this will hold QHPs accountable and strengthen health centers' financial viability in the future.

Essential Community Providers are also cited as "those who serve predominantly low-income, medically underserved individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service Act and described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act,"[22] part of the 340B statute, which grants covered entities access to the 340B Drug Pricing Program. The 340B program allows covered entities to provide more accessible pharmacy services and reasonably priced medications to their patients because they serve a disproportionate number of lower-income patients.

Including the ECP provision within the 340B statute shows how essential community providers, like health centers, are inextricably tied and rely heavily on the benefits of the 340B program. Under the same operating statute, the 340B program and ECP requirements share the same goal: to provide safety net providers with the resources they need to serve the most vulnerable and medically underserved communities. Health centers use their savings through the 340B program to meet the unique needs of health center communities with services such as dental care, behavioral health, specialty care, translation services, food pantries, and housing support. Health centers greatly benefit by participating in a stable 340B program to provide services and resources not funded by reimbursement or non-revenue generating services. It is essential for federal agencies, including CMS, to understand the implications of the current 340B attacks and the ability of essential community providers like Community Health Centers to serve Medicaid, Medicare, and Marketplace patients.

[22] https://www.cms.gov/files/document/ecp-listing-cover-sheet-03262013pdf#:~:text=Under%20that%20regulation%2C%20essential%20community,of%20the%20Social%20Security%20Act

The provisions in this proposed rule will positively impact health center patients' access to high-quality, affordable health coverage and care through enhanced enrollee protections and assurances that Essential Community Providers are being utilized. We greatly appreciate the opportunity to provide comments on this proposed rule. Should you have any questions about our comments, please feel free to contact Elizabeth Linderbaum, Deputy Director of Regulatory Affairs, at elinderbaum@nachc.org.

Sincerely,

Joe Dunn
Chief Policy Officer