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January 8, 2024

Xavier Becerra
Secretary
U.S. Department of Health and Human Services
Washington, DC 20201

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Submitted electronically: www.regulations.gov

RE: HHS Notice of Benefit and Payment Parameters for 2025 Proposed Rule (CMS-9895-P)

Dear Administrator Brooks-LaSure and Secretary Becerra:

The Healthcare Association of New York State, on behalf of our member nonprofit and public hospitals, nursing homes, home health agencies and other healthcare providers, appreciates the opportunity to comment on HHS' proposed Notice of Benefit and Payment Parameters for 2025.

HANYS is committed to supporting policies that build affordable, high-quality, and comprehensive health insurance coverage through federal and state marketplaces. HANYS supports many of the proposed changes in this rule, as they are aimed at increasing patient access to equitable care, providing clear information to consumers and reducing unnecessary obstacles.

HANYS offers the following specific comments.

31 CFR part 33 and 45 CFR Part 155 — Section 1332 Waiver procedures

CMS proposes Section 1332 Waivers for State Innovation regulation changes that would allow a state to hold a public hearing or post-award forum in a virtual or hybrid format. HANYS supports this proposal as it would enable a wider audience of constituents to access the hearing and provide comments. Receiving comments from a broad range of stakeholders allows agencies to craft better, more thoughtful policy, and this proposal supports that goal.

42 CFR Parts 435 — Medicaid Eligibility and Administration

Current regulations require that income and resource disregards must apply across all individuals in a particular Medicaid eligibility group. This lack of flexibility creates challenges for individuals with disabilities with various levels of resources and income saved. In some cases, these individuals may lose eligibility or be forced to exhaust savings that they were originally incentivized to accumulate. Based on the current regulations, states cannot address this problem without increasing the resource standard for everyone in the new group.

Therefore, CMS proposes to eliminate that regulation. This would allow states to target income or "resources disregards" at discrete subpopulations in the same eligibility group. These subgroups would have to be reasonable and not violate other federal statutes with discriminatory practices.

HANYS supports this proposal. Creating more flexibility around eligibility would allow states to target populations with the most need and expand eligibility, rather than contracting it.

42 CFR Parts 435 and 600 — Basic Health Program Regulations

Under the current BHP regulations, states have the option to choose between two methods for determining the effective date of eligibility. Depending on what day of the month an enrollee selects their plan, coverage will be effective the first day of the following month, or the first day of the second month. These options do not allow a state to enroll individuals effective the month following the month of application or eligibility determination.

CMS proposes to add an option for states to have an effective date of eligibility for all enrollees on the first day of the month following the month when BHP eligibility is determined. CMS is also seeking comments on whether to allow a third option: allowing states to establish their own uniform effective date, subject to approval and no later than the current timeline.

HANYS supports both proposals, which would allow states to streamline the effective dates for enrollees. Any policy that allows enrollees to access their coverage with the least amount of delay is an important step toward providing individuals with seamless access to healthcare.

§155.205 Consumer Assistance Tools and Programs of an Exchange

CMS proposes additional minimum standards for exchange call centers. The proposal would require them to provide live call center representatives during published hours of operation. The live call center representative must be able to help customers with Advance Premium Tax Credits and Cost Sharing Reduction eligibility, Qualified Health Plan options and QHP enrollment applications. CMS believes that all state exchanges already meet this standard; therefore, this proposal is meant to codify a consistent minimum standard across platforms. HANYS supports this proposal.

§155.305(f)(4) Failure to File and Reconcile

CMS proposes to require exchanges to send notices to tax filers after the first year in which they have been determined to have failed to reconcile the APTC, which would function as an initial

warning that they need to file and reconcile, or risk being ineligible for the APTC if they fail to do so for a second consecutive year.

HANYS supports this proposal as a method to help enrollees remain covered and avoid disenrollment for administrative reasons. However, we agree that failure to reconcile status constitutes Federal Tax Information, which is protected information.

HANYS suggests that CMS provide a model notice to states that contains the information enrollees need to rectify their status but does not contain protected information.

§155.410 Open Enrollment Periods

CMS proposes to require state exchanges, beginning Jan. 1, 2025, to adopt an open enrollment period that begins Nov. 1 of the calendar year preceding the benefit year, ending no earlier than Jan. 15 of the benefit year.

HANYS supports this proposal as it standardizes and aligns open enrollment periods, making it easier for enrollees to manage their coverage.

§155.420(b) — Special Enrollment Periods

Beginning Jan. 1, 2025, CMS proposes to require all state exchanges to provide coverage that is effective on the first day of the month following plan selection, during SEPs. HANYS supports this proposal to avoid delays in coverage for transitional enrollees.

§155.1050 — Establishment of Exchange Network Adequacy Standards

CMS proposes that state exchanges and state-based exchanges on the federal platform establish and impose quantitative time and distance network adequacy standards for QHPs that are at least as stringent as those required for federally facilitated exchanges.

State exchanges and SBE-FPs would also be required to conduct quantitative network adequacy reviews and require issuers to provide information about telehealth services before certifying any plan as a QHP.

Those issuers unable to meet the network adequacy standards would be allowed to participate in a justification process to account for variances. State exchange time and distance standards would be calculated at the county level and apply to provider specialty lists. These changes would go into effect Jan. 1, 2025.

HANYS supports these proposals to provide equitable services across geographic areas; however, we request that CMS allow a public comment period before the process for applying FFE network standards to state exchanges is finalized and implemented.

New York is committed to providing equitable care across the whole state and has already implemented robust network adequacy standards for exchange issuers. We support consistent standards but do not want to create duplicative or burdensome requirements.

§ 156.115 45 CFR Part 156 — Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

The proposed rule removes the regulatory prohibition on issuers from including routine non-pediatric dental services as an Essential Health Benefit. States that choose to include this benefit would be required to update their EHB benchmark plans to include those services.

HANYS supports the proposal to remove this prohibition and recommends that CMS make similar changes with regard to non-pediatric eye exam services, which would allow states to add benefits that can improve overall health outcomes. Currently in New York, enrollment in Stand-Alone Dental Plans is low for consumers who have chosen a health plan without dental coverage. Combining this coverage into benchmark plans would make it easier for enrollees to navigate their own coverage and have access to more comprehensive care.

HANYS recommends that CMS create an expedited path to adding routine, non-pediatric dental services as an EHB. The planned two-year waiting period means that consumers would be unable to access that benefit until plan year 2027, whereas New York is prepared to institute this program much sooner.

HANYS asks that CMS provide a definition of, or a benchmark for, what constitutes routine non-pediatric dental services, which would help states facilitate this new coverage and receive approval.

HANYS appreciates the opportunity to provide feedback on the proposed rule. If you have questions regarding our comments, contact me at 518.431.7889 or at vaufiero@hanys.org or Anna Sapak, manager, insurance and managed care, at 518.431.7871 or asapak@hanys.org.

Sincerely,

Victoria Aufiero
Vice President, Insurance, Managed Care and Behavioral Health