National
Family Planning
& Reproductive Health Association

March 15, 2013

Gary Cohen
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
US Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: **Comments on Affordable Exchanges guidance**

Dear Mr. Cohen:

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to respond to the guidance from the Center for Consumer Information and Insurance Oversight (CCIIO), Centers for Medicare & Medicaid Services (CMS) for qualified health plans (QHPs) participating in federally facilitated (FFE) and state partnership exchanges authorized by the Patient Protection and Affordable Care Act (ACA).

NFPRHA is a national membership organization representing the nation's family planning providers – nurse practitioners, nurses, administrators, and other key health care professionals. NFPRHA's members operate or fund a network of nearly 5,000 health centers and service sites that provide high-quality family planning and other preventive health services to millions of low-income, uninsured, or underinsured individuals in 49 states and the District of Columbia.

NFPRHA appreciates the additional guidance provided to QHPs as they prepare to organize provider networks and offer plans to millions of health care consumers. The additional guidance makes great strides towards ensuring that the safety net is properly included in ACA implementation. As the US Department of Health and Human Services (HHS) moves forward with implementing the exchanges, NFPRHA believes the policies outlined below should be included in the guidance to improve health care access for the millions of people who seek care from essential community providers (ECPs), including family planning service sites.

1. NFPRHA asks that CCIIO clarify the major ECP categories to promote access to the broadest possible range of safety-net providers.
2. NFPRHA asks that CCIIO strengthen the ECP sufficiency standard to require that at least one ECP in each ECP category is required for QHPs meeting the minimum expectation.
3. Finally, NFPRHA asks that CCIIO prohibit certification of QHPs that discriminate against family planning providers.

Chapter 1. Section 1: Network Adequacy and Inclusion of Essential Community Providers

CCIIO should clarify the major ECP categories to promote access to the broadest possible range of safety-net providers.

NFPRHA appreciates CCIIO's efforts to ensure that QHPs contract with providers who traditionally care for low-income patients and populations with limited access to health services as required by the ACA.[1] The final rule requires that QHPs have "a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals."[2] The guidance for QHPs strengthens this provision by outlining standards that QHPs must meet to comply with the ECP requirement. NFPRHA is pleased that under the "safe harbor standard" QHPs must include "at least one ECP in each ECP category in each county in the service area, where an ECP in that category is available."[3] Furthermore, the inclusion of Table 1.1 listing the various ECP categories and the specific inclusion of Title X and Title X "look-alike" health centers as a major ECP category helps promote individuals' access to high-quality family planning care.

NFPRHA asks that CCIIO clarify that QHPs must offer contracts to ECPs *prior to the first year of coverage* so that plan enrollees will have immediate access to services. Allowing QHPs to offer contracts *during the first year of coverage* conflicts with the ACA goal of promptly and efficiently expanding health care access to millions of individuals who have gone without coverage.

CCIIO should also clarify that QHPs cannot satisfy the safe harbor standard by offering contracts to individual entities that satisfy more than one major ECP category. There are many ECPs that receive funding from different public health funding programs. For example, several federally qualified health centers (FQHCs) also receive Title X family planning funds. As currently written, the guidance does not clearly state that a QHP cannot meet the safe harbor requirement if it contracts with one provider that satisfies more than one major ECP category.

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[1] Patient Protection and Affordable Care Act, § 1311(c)(1)(C), Pub. L. No. 111-148 (2010).

[2] "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans Federal *Register* 77:59 (March 27, 2012) p. 18470.

[3] Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, *Affordable Exchanges Guidance: Letter to Issuers on Federally-facilitated and State Partnership Exchanges*,

CCIIO will limit the breadth of the provider networks if QHPs are allowed to meet the safe harbor requirement by contracting with one provider with funding support from multiple public health programs. Moreover, there are providers supported by multiple public health programs that are inaccessible to a diverse population of patients. For example, some tribal organizations receive Title X family planning funds. Tribal providers cannot be expected to expand their capacity to serve all of the individuals located in a QHP's service area. This is true of migrant health centers that also receive funding from the Centers for Disease Control and Prevention's Division of STD Prevention.

Millions of women and men rely on family planning health centers for a wide range of preventive health services. It is imperative that Title X health centers and Title X look-alikes are included in QHP networks to ensure that their patients who may become newly insured under the ACA can continue to access their services. A recent study highlights the value of family planning providers to women seeking sexual and reproductive health services. According to the study, "The women surveyed chose to seek care at a specialized family planning clinic, even though they had other choices in their communities."[4] In addition to the confidentiality protections afforded patients in Title X systems, women in the study cited the staff's knowledge about sexual and reproductive health issues, and the ease with which they could access contraception as reasons for why they chose family planning providers. By clarifying the safe harbor standard for QHPs, CCIIO will help ensure that women can continue to access their preferred providers as they become enrolled in exchange plans.

NFPRHA asks that CCIIO strengthen the ECP sufficiency standard to require that at least one ECP in each ECP category is required for QHPs meeting the minimum expectation.

NFPRHA asks that CCIIO apply the requirement from the safe harbor standard that QHPs offer contracts to at least one ECP in each ECP category to the minimum expectation. While recognizing that health insurance varies significantly by location, NFPRHA is concerned that many QHPs will choose the minimum expectation to satisfy the sufficiency requirement, thus potentially excluding many safety-net providers from participation in affordable exchanges. Allowing QHPs to submit a narrative justification attesting that its network provides an adequate level of service for the medically underserved does not sufficiently protect consumer access to health care. The ACA intends to expand insurance coverage to over 30 million currently uninsured individuals at a time when there is a growing provider shortage, particularly in the areas of preventive and primary care.[5] CCIIO should encourage QHPs to contract with a diverse and robust network of safety-net providers to enable those individuals enrolled in their

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[4] Jennifer Frost, Rachel Gold, and Amelia Bucek, "Specialized Family Planning Clinics in the United States: Why Women Choose Them and Their Role in Meeting Women's Health Care Needs," *Women's Health Issues,* 22-6 (2012), e519-e525.

[5] Elbert Huang and Kenneth Finegold, "Seven Million Americans Live in Areas Where Demand for Primary Care May Exceed Supply by More than 10 Percent," *Health Affairs* 10.1377-2012.0913 (February 2013).

plans to access care without barriers, particularly those who have been denied coverage in the past because of high-cost health conditions. By including the requirement to the minimum expectation that QHPs contract with at least one ECP in each ECP category, CCIIO would strengthen the ability of consumers to access safety-net providers who are experts in delivering their care. Moreover, more than 13 million women are expected to gain health insurance coverage under the ACA.[6] It is imperative that they can continue to access the family planning providers that they have traditionally relied upon for preventive care.

HHS should prohibit discrimination against family planning providers by QHPs participating in the FFE

The state-based exchanges final rule includes several provisions designed to protect reproductive health providers from discrimination. NFPRHA is pleased that the letter to QHPs reinforces these protections by identifying Title X and Title X look-alikes under a major ECP category. Family planning health centers regularly incur discrimination by plans with ideological objections to contraception and other sensitive sexual health services. The need to offer women and men access to comprehensive health services, not the ideology of any one health plan, should guide which providers are made available to patients.

Additional guidance to QHPs should detail how the certification process will include measures to protect safety-net providers, including Title X health centers, from discriminatory contracts. NFPRHA is concerned that some QHPs will offer contracts that fail to cover all of the family planning services available to the beneficiary under the plan or reduce reimbursement based on the provider's status as an ECP. Family planning health centers or clinicians they employ are frequently presented with health plan contracts that pay them lower reimbursement rates than other providers for the provision of the same services.[7] The state-based exchange rule clarifies that "'generally applicable payment rate' means, at a minimum the rate offered to similar situated providers who are not essential community providers."[8] Guidance to QHPs participating in the FFEs or the state partnership exchanges should include the same clarification and make plan acceptance subject to oversight of the contracts offered to ECPs. Family planning health centers, staffed primarily by mid-level providers, are at a particular disadvantage when negotiating health plan contracts and would benefit from enhanced oversight of the process by the FFE administrator.

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[6] Alison Cuellar, Adelle Simmons, and Kenneth Finegold, *The Affordable Care Act and Women*, Health and Human Services, 2012, accessed March 13, 2013, http://aspe.hhs.gov/health/reports/2012/ACA&Women/rb.shtml#_ftn18.

[7] National Association of Pediatric Nurse Practitioners, "NAPNAP Position Statement on Reimbursement for Nurse Practitioner Services," *Journal of Pediatric Health Care,* vol. 23 no. 6 (November/December 2009).

[8] "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers." *Federal Register* 77:59 (March 27, 2012) p. 18422.

CCIIO should also encourage QHPs to credential nurses for the services they are licensed to provide. Family planning health centers are typically nurse-managed centers and third-party payers may not recognize or credential nurses, adversely impacting the health center's ability to bill insurance. Patients enrolled in ACA-affiliated coverage could be subject to incredibly long wait-times or need to travel unreasonable distances for care if some clinicians are not working at their capacity because of discriminatory contracting practices by health plans. ECPs are frequently required to care for "all comers" in the communities in which they serve. Unfair contracting practices by QHPs can mean fewer health services for plan enrollees or require ECPs to unnecessarily provide uncompensated care as a way of cost shifting onto community-based providers. CCIIO will help guarantee the accessibility of a diverse network of community-based providers with a history of caring for millions of underserved people by adopting policies that protect family planning and other ECPs.

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NFPRHA appreciates the opportunity to comment on CCIIO's additional guidance to QHPs preparing to participate in affordable exchanges. If you require additional information about the issues raised in this letter, please contact Dana Thomas at 202-293-3114 ext. 206.

Sincerely,

Clare M. Coleman

Clare Coleman
President & CEO