National
Family Planning
& Reproductive Health Association

February 25, 2014

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: **Draft 2015 Letter to Issuers in the Federally-facilitated Marketplaces**

Dear Mr. Cohen:

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to respond to the Draft 2015 Letter to Issuers in the Federally-facilitated Marketplace (FFM) released by the Center for Consumer Information and Insurance Oversight (CCIIO) within the Centers for Medicare & Medicaid Services (CMS) for qualified health plans (QHPs) participating in FFMs as 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 50 states and the District of Columbia. Services are provided through state, county, and local health departments as well as hospitals, family planning councils, Planned Parenthoods, federally qualified health centers and other private non-profit organizations.

NFPRHA appreciates CMS' efforts to address concerns safety-net providers have raised with the administration in its draft guidance for the 2015 plan year. The guidance makes important strides toward ensuring that the safety net is appropriately included in provider networks and offers insurers a less complicated approach to their inclusion. However, there is still more work to be done to ensure that consumers have robust access to the providers and health care they need to stay healthy.

NFPRHA believes the policies in **Chapter 2. Section 4: Essential Community Providers** in the draft letter should be expanded as outlined below:

1. NFPRHA urges CCIIO to continue to increase the ECP contracting requirement and asks that CCIIO communicate to plans that the 30% threshold is a floor, not a ceiling.
2. NFPRHA requests that CCIIO strengthen the ECP sufficiency standard to require that a contract must be established with, rather than merely offered to, at least one ECP in each ECP category for QHPs to meet the requirement. NFPRHA would also like to reiterate to CCIIO that robust monitoring of networks is just as important as the initial certification period.
3. NFPRHA requests that CCIIO clarify the purpose and use of the non-exhaustive ECP database.

NFPRHA urges CCIIO to continue to increase the ECP contracting requirement and asks that CCIIO communicate to plans that the 30% threshold is a floor, and encourage health plan issuers to include a greater number of ECPs.

NFPRHA appreciates CCIIO's expanded requirement for health insurance issuers to contract with 30% of ECPs and its effort to reduce the burden on health plans by creating one standard for certification. This strengthened requirement shows commitment on the part of CMS that is in line with the spirit of the ACA requirement that issuers include health care providers that have traditionally cared for poor, low-income, and medically underserved individuals.[1] While NFPRHA is appreciative of a more robust standard, we urge CCIIO to continue to raise the standard. The guidance states that only one issuer used the minimum expectation standard in 2014, which leads NFPRHA to believe that plans have the ability to contract with a wider network of ECPs. In addition, some states have been able to successfully establish higher thresholds.

NFPRHA also requests that CCIIO's final guidance reiterate that 30% is a floor, not a ceiling for contracting with ECPs, and encourages health plan issuers to work with a greater number of ECPs. Since many of the newly insured individuals seeking access through FFM plans were previously uninsured and accessed health care through the safety net, maintaining their ability to access their existing, trusted family planning providers and other ECPs is important. Millions of women and men rely on family planning health centers for a wide range of preventive health services. More than 13 million women are expected to gain health insurance coverage under the ACA.[2] It is imperative that Title X-funded health centers and Title X look-

[1] Patient Protection and Affordable Care Act, § 1311(c)(1)(C), Pub. L. No. 111-148 (2010).
[2] Alison Cuellar, Adelle Simmons, and Kenneth Finegold, *The Affordable Care Act and Women*, Health and Human Services, 2012, accessed February 20, 2014, http://aspe.hhs.gov/health/reports/2012/ACA&Women/rb.shtml#_ftn18.

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.

NFPRHA requests that the guidance clarifies the narrative justification requirements to require that issuers submitting a justification must include the names of *all* the ECPs to which the issuer has offered contracts, rather than just hospitals and federally qualified health centers (FQHCs) as currently listed. As written, many required ECP groups are left out of the justification process.

Finally, 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 long wait-times or need to travel unreasonable distances for care if some clinicians are not able to bill 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 lead to fewer health services for plan enrollees or uncompensated care by community-based providers. CCIIO would 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 ECPs.

NFPRHA asks that CCIIO strengthen the ECP sufficiency standard to require that a contract is established with, rather than merely offered to, at least one ECP in each ECP category to meet the requirement. Robust monitoring of networks is just as important as the initial certification period.

NFPRHA requests that CCIIO strengthen the ECP standard by requiring that QHPs establish contracts with ECPs rather than just showing contracts were offered. Allowing QHPs to offer rather than establish legal agreement erodes the overall goal of the guidance and could possibly allow plans to offer contracts but not follow through on them. Further, the good faith standard should be strengthened to require that the comparison plan for a similarly situated, non-ECP provider be a contract that would be considered median in terms of reimbursement rates. NFPRHA is concerned that without additional clarification issuers could use a low-reimbursing contract as verification, forcing ECPs into lower reimbursement rate contracts.

Continual monitoring of QHP networks is as important as the initial certification period. Because contracts can be added, amended, or dropped throughout the plan year, there is the possibility that issuers can submit a robust network plan without maintaining the network throughout the year. This could cause access to health care to be diminished for plan enrollees, who may be unable to change plans throughout the year.

NFPRHA asks that CCIIO clarify the purpose and use of the non-exhaustive ECP database.

The non-exhaustive ECP database is an important tool for health plan issuers to use in their efforts contracting with ECPs. NFPRHA asks that the write-in requirements, in particular, be clarified. As currently written, the guidance could dissuade QHPs from seeking out multiple types of ECPs that happen to co-locate, such as STD services and family planning services co-locating in community action agencies or local health departments. This type of co-location commonly occurs in safety-net settings, and the only tie from one program to another may be a common address at an administrative office. NFPRHA is concerned that these types of providers could be put at a disadvantage by only counting allowing issuers to write-in one ECP per address. NFPRHA asks CCIIO to monitor this issue to ensure that this regulation does not negatively impact the number of ECPs included in QHP contracts.

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NFPRHA appreciates the opportunity to comment on CCIIO's additional guidance to QHPs preparing to participate in affordable marketplaces. If you require additional information about the issues raised in this letter, please contact Julie Lewis at 202-293-3114 ext. 214 or at jlewis@nfprha.org.

Sincerely,

Clare Coleman
President & CEO