National
Family Planning
& Reproductive Health Association

December 22, 2014

Centers for Medicare & Medicaid Services
US Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

ATTN: CMS-9944-P

Re: **Comments on Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2016**

Dear Sir or Madam:

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to respond to the proposed rule issued by the Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) related to a broad range of Affordable Care Act (ACA) provisions, including essential health benefits (EHB), network adequacy, and essential community providers (ECPs).

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 the strong commitment of HHS and CMS to ensure that implementation of the ACA considers the needs of safety-net providers, including providers of publicly funded family planning, and the women and men that they serve.

* * *

1627 K Street, NW, 12th Floor, Washington, D.C. 20006-1702 • Phone 202.293.3114 • www.nfprha.org

ESSENTIAL COMMUNITY PROVIDERS (ECP)

NFPRHA appreciates CMS' efforts to address concerns safety-net providers have raised and to strengthen the ECP standard. 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 also applauds CMS's clarification that multiple providers at a single location count as a single ECP for the purposes of satisfying the participation standard. This distinction helps to ensure more adequate networks that include a broader array of safety-net providers.

NFPRHA requests that CMS include the clarification of family planning service site eligibility into the regulation text.

NFPRHA applauds CMS' clarification in the preamble of the proposed rule that the definition of essential community provider includes "not-for-profit or governmental family planning service sites that do not receive a grant under Title X of the Public Health Service Act." This is an important distinction, particularly as Title X dollars continue to decrease, and safety-net family planning health centers are forced to diversify revenue streams to remain viable and sustainable. However, NFPRHA requests that CMS include this clarifying language in the regulation text itself, making it explicit that family planning service sites that do not receive Title X funding qualify as ECPs under section 1927(c)(1)(D)(i)(IV) of the Social Security Act.

NFPRHA proposes that the section 156.235(c) of the regulation text read as follows:

"An essential community provider is a provider that serves predominantly low-income medically underserved individuals, including a health care provider defined in section 340B(a)(4) of the PHS Act; or described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Public Law 111-8, <u>including not-for-profit or governmental family planning service sites that do not receive a grant under Title X of the PHS Act."</u>

NFPRHA asks that CMS strengthen the ECP quantitative participation standard to require that standard to increase over time.

NFPRHA requests that CMS strengthen the ECP quantitative participation standard by adding regulatory language requiring that the standard continue to increase over time. NFPRHA supports the decision to revisit the percentage on an annual basis and publish that percentage in guidance, rather than codifying a specific percentage in regulation. However, NFPRHA requests that CMS continue to encourage 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. In addition, through Medicaid expansion and advanced premium tax credits for people between 100% and 400% of the federal poverty line, the ACA has increased the number of low-income Americans with health insurance coverage. These individuals will likely be an increasing percentage of the patient population of safety-net family planning health centers, given that millions of these women and men rely on family planning health centers for a wide range of preventive health services. It is imperative that Title X-funded health centers and Title X look-alikes continue to be included in QHP networks to ensure that their patients who may become newly insured under the ACA can continue to be able to access their services.

NFPRHA asks that CMS 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 CMS 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 CMS clarify that the ACA's non-discrimination provisions apply to contracting with essential community providers.

Section 2706(a) of the Public Health Service Act, as added by the ACA, prohibits issuers of group or individual health coverage to discriminate, with respect to participation, against any provider practicing within their prescribed scope and under applicable state law. NFPRHA requests that CMS clarify that Section 2706(a) applies to contracting with ECPs, and that issuers may not discriminate based on the services provided. Due to the perceived controversial nature of family planning and other women's health services in some locations, there is already

precedent of policymakers excluding specialized family planning health centers from Medicaid networks based solely on the types of services of they provide. NFPRHA is concerned that similar discrimination or tiering of providers might be occurring among issuers, as well as in state list of ECPs.

ESSENTIAL HEALTH BENEFITS (EHB)

NFPRHA applauds CMS' efforts to ensure that the prescription drug formularies complying with the EHB cover an appropriate range of drugs based on broadly accepted treatment guidelines and that coverage is not discriminatory based on "age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions." However, with respect to the proposed switch from the United States Pharmacopeia (USP) to the American Hospital Formulary Service (AHFS) for the drug count standard, NFPRHA is concerned about the restricted availability of the AHFS. Given its tie to Medicare, the USP standard certainly has its drawbacks, particularly in the family planning context. However, without being able to review all the tiers of the AHFS more closely, it is difficult to determine if this proposed switch would be a positive change. In general, NFPRHA would support transitioning from the USP to a standard that has a broader range of categories and classes, but request that whatever standard is used be one that is publicly available.

NFPRHA asks that CMS explicitly state that EHB coverage requires inclusion of the women's preventive services benefit above and beyond the prescription drug benefit, and that the drug count standard does not apply to contraceptive methods.

Section 2713(a)(4) of the Public Health Service Act, as amended by the ACA, requires all health plans to cover a set of preventive health services designed to meet the unique health care needs of women. In a historic victory for women's health, HHS adopted a set of benefits that will increase access to important health services at no cost-sharing to the consumer. The women's health preventive services benefit requires that health plans cover all FDA-approved contraceptive methods, contraceptive counseling, and the family planning visit, as well as a number of other important women's health services. It is imperative that these important benefits are covered for every woman of reproductive capacity with health insurance. NFPRHA is concerned that in the process of developing drug formularies, insurance issuers are conflating the required prescription drug coverage in the EHB with coverage of all FDA-approved methods of contraception required in the women's preventive services benefit. NFPRHA requests that CMS explicitly state that the women's preventive services benefit is a distinct and separate requirement above and beyond the prescription drug coverage included in the EHB. In addition,

NFPRHA asks CMS to clarify that the drug count standard, whether it uses the United States Pharmacopeia (USP) or the American Hospital Formulary Service (AHFS), does not apply to the required coverage of all FDA-approved methods of contraception included in the women's preventive services benefit.

NFPRHA asks CMS to explicitly state that contraceptive methods with different modes of delivery are unique methods, and that the women's preventive services benefit requires coverage of all of those unique methods with no cost-sharing.

NFPRHA was disappointed to see that CMS did not take this proposed rule as an opportunity to reiterate and clarify that all FDA-approved methods of contraception are required to be covered with no cost-sharing. NFPRHA and other organizations have shared with HHS countless examples of health insurance issuers across the country placing certain contraceptive methods (e.g. the Nuvaring) into higher tiers of their prescription drug formularies under the guise of reasonable medical management techniques and with the justification that another method with the same hormonal formulation, but a different delivery mode (e.g. a generic oral contraceptive), is available with no cost-sharing. NFPRHA requests that CMS prohibit this practice and clarify that a variation in mode of delivery constitutes a unique contraceptive method.

***

NFPRHA appreciates the opportunity to comment on the benefit and payment parameters proposed rule. If you require additional information about the issues raised in this letter, please contact Mindy McGrath at 202-293-3114 ext. 206 or at mmcgrath@nfprha.org.

Sincerely,

Clare Coleman
President & CEO