National
Family Planning
& Reproductive Health Association

December 21, 2015

US Department of Health and Human Services
Center for Medicare & Medicaid Services
200 Independence Avenue, SW
Room 445G
Washington, DC 20201

Re: **2017 Benefit and Payment Parameter Notice of Proposed Rule-Making (CMS-9937-P)**

Dear Acting Administrator Slavitt:

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to respond to the 2017 benefit and payment parameter proposed rule issued by the US 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 network adequacy and essential community providers (ECPs).

NFPRHA is a national membership organization representing providers and administrators committed to helping people get the family planning education and care they need to make the best choices for themselves and their loved ones. 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, the District of Columbia, as well as US territories. 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 nonprofit organizations.

NFPRHA commends HHS and CMS for their ongoing commitment to increasing coverage, particularly for low-income and medically underserved individuals, and ensuring adequate access to a patient's provider of choice. In addition to the more detailed comments below, NFPRHA would like to applaud HHS' proposed change to §155.605(d)(5), removing the requirement to obtain a Medicaid eligibility determination to qualify for an exemption in states that have opted not to expand their Medicaid programs. Safety-net family planning providers working to help their patients enroll in coverage have encountered problems in this area, with patients who knew they would not qualify for Medicaid and chose not to apply. This will ease

the process for these individuals whose states have chosen to leave them without coverage options.

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NETWORK ADEQUACY

NFPRHA urges HHS to establish network adequacy standards that ensure enrollees have timely access to family planning and sexual health services and providers.

The proposed regulations include welcome steps to address some of the current problems with network adequacy, including new requirements at § 156.230 announcing the plan to establish federal standards and a process for assessing network adequacy reviews done by states. NFPRHA has several recommendations for strengthening these requirements and ensuring enrollees' timely access to the full range of covered services.

We are pleased that HHS plans to establish a federal default standard for network adequacy, which would include specific measures of travel time and distance to determine whether the networks of qualified health plan (QHP) issuers are adequate. However, for family planning and sexual health services, a time and distance standard or provider-to-enrollee ratio is not sufficient to address timely access to care. There is no guarantee a woman will be able to access the care she needs in a timely manner simply because a provider of those services is in close proximity to where she lives. Thus, NFPRHA urges HHS to specify that network adequacy standards must incorporate waiting times for initial appointments for time-sensitive services, specifically family planning services and supplies. Timely access to appointments is critical, as any delay in accessing family planning care can lead to an unintended pregnancy.

Additionally, NFPRHA urges HHS to include family planning and sexual health providers in any network adequacy standards for specific provider types. To ensure that women have meaningful access to all covered family planning and sexual health services, the final regulations should include network adequacy standards that encompass not only access to OB/GYNs but the full range of family planning and sexual health providers, which includes nurse practitioners, certified nurse midwives, physician assistants, and other non-physician practitioners.

NFPRHA requests that HHS modify the notification requirements regarding a discontinued provider in order to protect patient confidentiality.

In the new §156.230(e)(1), HHS proposes requiring QHP issuers in federally facilitated marketplace states to "make a good faith effort to provide written notice of a discontinued provider, 30 days prior to the effective date of the change or otherwise as soon as practicable, to all enrollees who are patients seen on a regular basis by the provider or receive primary care from the provider whose contract is being discontinued." NFPRHA is concerned that this process could pose a risk to the confidentiality of minors or adult dependents who have sought family planning or sexual health services. In general, communications from the issuer are directed to the policyholder, not necessarily the individual who is the patient of any given provider.

If a provider that is being discontinued from the network is obviously a provider of family planning and sexual health services, and the patient that has been seeking those services is a minor or adult dependent who wishes to keep those services confidential from the policyholder, this notification could pose a risk to the dependent. NFPRHA recommends that the proposed notification requirement be revised so that the issuer be required to notify all enrollees of a provider discontinuation, regardless of whether or not that enrollee is an existing or regular patient of said provider. This revised notification process would accomplish the same goal of provider network transparency while protecting patient confidentiality and keep all enrollees informed of changes in the provider network throughout the year. The notifications could be batched on a monthly basis, e.g., all of the providers being discontinued in a calendar month could be included in the same notification, to improve efficiency.

ESSENTIAL COMMUNITY PROVIDERS

NFPRHA requests that HHS clarify that nonprofit and governmental family planning services sites that do not receive a grant under Title X of the Public Health Service Act are included in section 1927(c)(1)(D)(i)(IV) of the Social Security Act, rather than an additional category.

In the 2016 Benefit and Payment Parameter NPRM, NFPRHA requested that the clarification included in the preamble of the proposed rule that the definition of essential community provider includes "nonprofit or governmental family planning service sites that do not receive a grant under Title X of the Public Health Service Act" be included in the regulatory text itself. NFPRHA proposed that §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, ***including*** nonprofit or governmental family planning service sites that do not receive a grant under Title X of the PHS Act." This distinction is important, particularly as Title X funding continues to be cut, and safety-net family planning health centers are forced to diversify revenue streams to remain viable and sustainable. In the 2016 Benefit and Payment Parameter final rule, NFPRHA was pleased to see that HHS had made this requested change. However,

instead of using the "including," to indicate that nonprofit or governmental family planning service sites are included under section 1927(c)(1)(D)(i)(IV), the final regulation text states that:

> "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 Pub. L. 111-8; ***or*** a State-owned family planning service *site* ***or*** governmental family planning service site, ***or*** not-for-profit family planning service site that does not receive Federal funding under special programs, including under Title X of the PHS Act, or an Indian health care provider, unless any of the above providers has lost its status under either of these sections, 340(B) of the PHS Act or 1927 of the Act as a result of violating Federal law."

This small distinction in wording could be interpreted to mean that nonprofit or governmental family planning service sites are not actually included in the definition at section 1927(c)(1)(D)(i)(IV) of the Social Security Act, which grants nominal drug pricing to the entities described therein. Manufacturers have used this ambiguity to argue that they are not required to offer nominal drug pricing to this type of family planning service sites. In a September 17, 2015, letter to Victoria Wachino, Director of the Center for Medicaid and CHIP Services, NFPRHA joined the Guttmacher Institute, the National Women's Law Center, and the Planned Parenthood Federation of America in requesting that this clarification be made. NFPRHA reiterates that request in these comments.

NFPRHA urges HHS to maintain the current policy that multiple providers at one location count as a single ECP for the purposes of meeting the percentage threshold.

In §156.235, HHS proposes that beginning in the 2018 benefit year, QHP issuers be credited "for multiple contracted full-time equivalent (FTE) practitioners reported to HHS by the ECP facility through the provider petition process and published on the HHS ECP list." NFPRHA recognizes that the goal of this proposal may be to ensure access to care by looking at the number of health care clinicians that provide care at ECP locations. However, there are several reasons why this proposal would not meet this goal, and instead, may undermine access to ECPs and undermine the intent of the ACA's ECP provision. Firstly, tracking and reporting FTEs is often difficult and fluctuates through the year. Title X grantees report this data for the Family Planning Annual Report (FPAR), but the data are aggregated across a grantee's entire network. Providers often split their time across multiple service sites or practice under a volunteer agreement, making it onerous and overly burdensome for some to calculate accurate FTE data on the service site level. In addition, clinicians may come and go or move from service site to another throughout a year, but the FTE data from the ECP petition is only calculated once per year, further adding to the inaccuracy of the number.

The proposed change to the way ECPs are counted also does not account for the geographic distribution of providers or an adequate range of provider types, undermining the intent of the ACA. For example, an issuer could meet the 30% threshold by contracting with 30 FTE out of 100 FTE in the area, but most or all of the contracted FTES could be from the same facility and not geographically accessible to everyone in the service area.

Furthermore, from a practical perspective, individual clinicians do not usually contract directly with a QHP issuer. Instead, the facility or organization contracts with the issuer and then the issuer credentials each individual clinician so that the clinician can bill that insurance. Credentialing takes time – three months to a year, at times. Under this proposed process, the ECP reports the number of FTEs at their location in the ECP petition, and this information is then included in the annual ECP list. If an issuer is allowed to count FTEs toward the numerator (for purposes of the ECP percentage threshold), would the issuer count *only* the FTEs that are *credentialed* by that plan? If the goal is to ensure access to clinicians that can actually bill a health plan, at the very least it is critical to only allow issuers to count FTEs that accept the plan (not all clinicians at the ECP site the issuer is contracted with). If this is the case, this might be administratively burdensome for issuers to figure out which individual clinicians are credentialed under each health plan for purposes of calculating and meeting the ECP threshold. For all of the reasons above, NFPRHA strongly urges HHS to maintain the current method for counting ECPs.

NAVIGATORS AND CERTIFIED APPLICATION COUNSELORS

NFPRHA requests that preference be given to safety-net providers in the navigator funding review process

In §155.210(e), HHS has proposed requiring "navigators in all exchanges to provide targeted assistance to serve underserved and/or vulnerable populations within the exchange service area." Safety-net family planning providers, including Title X-funded health centers, serve these populations by design, and many of these providers have demonstrated ongoing commitment to increasing coverage for their patients. However, outside funding resources have begun to dry up, and many health centers can no longer afford to pay dedicated in-person assisters. In many instances, health centers have trained center staff—medical assistants, administrative staff, etc.—to become in-person assisters and have reorganized clinic flow to allow for time to help patients with enrollment. However, additional funding is needed to be able to reach more people without compromising the delivery of health care services and other necessary operations of a health center.

Given that safety-net family planning providers serve the very population that HHS is seeking to target with the navigator program, NFPRHA requests that safety-net providers, including Title X-funded health centers, be given preference in the funding review process for navigator grants.

NFPRHA requests that the certified application counselor organization reporting be collected quarterly, rather than monthly.

HHS has proposed requiring certified application counselor (CAC) organizations report performance data to the exchange on a monthly basis in §155.255(b)(1). NFPRHA supports the goals of this data reporting of increasing oversight of CAC organizations and informing outreach and education efforts, recruitment, and training needs. However, NFPRHA is concerned that the frequency of monthly reporting may be overly burdensome for Title-X funded health centers and other safety-net family planning providers. NFPRHA proposes that CAC organization reporting be required on a quarterly basis, with the understanding that reporting might need to be more frequent during open enrollment, when the bulk of CAC work is being done.

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NFPRHA appreciates the opportunity to provide comment on the 2017 benefit and payment parameter proposed rule. If you require additional information about the issues raised in this letter, please contact Mindy McGrath, NFPRHA Policy Director, at 202-293-3114 ext. 206 or at mmcgrath@nfprha.org.

Sincerely,

Clare Coleman
President & CEO