

National
Family Planning
& Reproductive Health Association

October 6, 2016

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

Re: **2018 Benefit and Payment Parameter Notice of Proposed Rule-Making (CMS-9934-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.

ESSENTIAL COMMUNITY PROVIDERS

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

In the 2017 Benefit and Payment Parameter final rule, HHS confirmed 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.” HHS is now proposing to continue the current methodology of counting multiple ECPs at a single location as one ECP. NFPRHA applauds the decision to postpone this change in methodology and encourages HHS to make this postponement permanent. There are several reasons why this proposal would undermine access to ECPs and 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 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, it would likely 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 permanently maintain the current method for counting ECPs.

NETWORK ADEQUACY

NFPRHA urges HHS to include the adequacy of a plan's inclusion of family planning and sexual health providers in the proposed network breadth tool.

NFPRHA appreciate HHS efforts to rate each QHP's relative network breadth on HealthCare.gov, and its willingness to include additional details into the network breadth indicator. Currently, consumers have no way of knowing the relative breadth of their plan's network. As an increasing number of plans offer narrow networks and limited access to providers, it is critically important that consumers understand the breadth of a plan's network and be able to make a meaningful choice in coverage.

The network breadth indicator will allow consumers to compare across plans' provider networks, an important aspect affecting consumers' ability to access care. However, without the tool including specific information about the accessibility of family planning and sexual health providers, the tool could be harmful – and not helpful – to a woman's ability to access care. HHS should ensure that any additions to the network breadth tool with respect to family planning and sexual health providers should encompass not only OB/GYNs, but the full range of providers of this care, which includes nurse practitioners, certified nurse midwives, physician assistants, and other non-physician practitioners. Furthermore, NFPRHA urges HHS to ensure that the network breadth tool explicitly note whether a plan excludes reproductive health services, including abortion, based on religious or moral objections.

Six in ten patients seeking care at a Title X-funded health center report that health center as their primary source of care. Four in ten patients report their Title X-funded health center as their **only** source of care. It is critical that the 2.5 million women of reproductive age who access coverage through the Marketplace can accurately ascertain if a plan's network includes their trusted sources of family planning and sexual health care.

NFPRHA appreciates the opportunity to provide comment on the 2018 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