National
Family Planning
& Reproductive Health Association

June 10, 2014

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

ATTN: CMS-9942-NC

Re: **Provider Non-discrimination Request for Information**

Dear Sir or Madam:

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to respond to the request for information regarding provider non-discrimination released by the Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS), Department of Labor's (DOL) Employee Benefits Security Administration (EBSA), and the Department of the Treasury's Internal Revenue Service (IRS).

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 shares the concern of the Senate Committee on Appropriations regarding the interpretation of section 2706(a) of the Public Health Service Act in the Frequently Asked Questions (FAQ) issued on April 29, 2013. The FAQ interpretation would allow non-grandfathered group health plans and health insurance issuers offering group or individual coverage beginning on or after January 1, 2014 to discriminate against providers based on type, services provided, and/or populations served. NFPRHA believes that section 2706(a) was

intended to prevent provider discrimination more broadly than the administration's interpretation of the provision.

Providers at NFPRHA-member organizations would be at risk of discrimination under the agencies' interpretation of section 2706(a) for several reasons, including: the high proportion of non-physician providers serving as clinicians; the perceived controversial nature of family planning and other women's health services in some locations; and their predominantly low-income, medically underserved patient population. For example, family planning health centers are typically nurse-managed centers. If allowed to discriminate by provider type, third-party payers may not recognize or credential nurses, adversely impacting the health center's ability to bill insurance. Patients 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. Additionally, 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[i]. The broad language included in the FAQ could open the door to more systematic and pervasive attacks on the family planning safety net including those who receive federal funding through the Title X family planning program, which is in opposition to the spirit of the provider nondiscrimination clause.

NFPRHA urges HHS, DOL, and the Department of the Treasury to clarify that section 2706(a) of the Public Health Service Act strengthens the Essential Community Provider (ECP) standard.

The FAQ interpretation of section 2706(a) goes contrary to the robust commitment the administration has demonstrated to preserving the safety net through the continued strengthening of the essential community provider (ECP) designation. The ECP designation was in the ACA to ensure that providers predominantly serving low-income, medically underserved individuals would be included in the new insurance marketplaces. The Affordable Care Act (ACA) requires that all insurance plans offered through the health insurance marketplaces (also known as Qualified Health Plans or QHPs), contract with at least some ECPs in their region. CMS' own *2015 Letter to Issuers in the Federally-facilitated Marketplaces* strengthened the ECP standards, requiring that QHPs contract with at least 30% of the ECPs in their area, including at least one from each ECP type: Federally Qualified Health Centers (FQHC); Ryan White HIV/AIDS Program providers; Title X family planning clinics; Indian Health Service providers; some hospitals; and a few other designations.[ii] In fact, the letter made clear that because few plans had difficulty contracting with ECPs, CMS felt confident they could strengthen the standard without burdening health plans.

The ECP designation was established with the understanding that the safety net will remain a trusted and needed source of health care for many, and with the acknowledgement that gaining insurance coverage should not force individuals to leave their provider of choice. Research shows that higher rates of insurance coverage do not translate into less patient volume at family planning health centers and other safety-net providers. A recent report by the

Centers for Disease Control and Prevention (CDC) showed that despite the fact that health reform in Massachusetts expanded coverage for most people living in the state, Title X health centers continued to have high volumes of patients, both uninsured and insured, and remained providers of choice for many.[iii] Research on the initial period following health reform showed that visits to Massachusetts safety-net providers grew by 31%.[iv]

Continued access to safety-net providers should not only be preserved for those individuals who obtain coverage through the Marketplaces. Individuals participating in group health plans or other non-marketplace coverage should also have the option to maintain their relationships with their current safety-net provider. The FAQ interpretation would open the door to health insurance issuers excluding safety-net providers from their networks, unnecessarily limiting access for the individuals covered by these plans.

NFPRHA urges HHS, DOL, and the Department of the Treasury to remove "market standards and considerations" from the factors issuers can use to determine reimbursement rates.

NFPRHA is concerned that including "market standards and considerations" in the determination of reimbursement rates will put Title X family planning health centers and other safety-net providers at a significant disadvantage in their efforts to contract with health plans. The ECP standard requires that QHPs offer contracts with "terms that a willing, similarly-situated, non-ECP provider would accept or has accepted."[v] NFPRHA believes this language is intended to ensure adequate reimbursement rates for ECPs. However, allowing "market standards and considerations" to determine reimbursement rates could lead issuers to justify offering safety-net providers rates so insufficient that those providers will be forced to deem contracting with plans not feasible or sustainable.

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Safety-net providers care for "all comers" in the communities in which they serve. Allowing discriminatory contracting practices by health insurance issuers can lead to fewer health services for plan enrollees or uncompensated care by community-based providers. CMS, EBSA, and IRS 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 do not allow discrimination by provider type, services provided, or populations served.

NFPRHA appreciates the opportunity to comment on the joint RFI from HHS, DOL, and the Department of the Treasury. 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 M. C

Clare Coleman
President & CEO

[i] Rachel Benson Gold, "Besieged Family Planning Network Plays Pivotal Role," *Guttmacher Policy Review* 16, no. 1 (Winter 2013). http://www.guttmacher.org/pubs/gpr/16/1/gpr160113.html

[ii] US Department of Health and Human Services, Center for Consumer Information and Oversight, 2015 Letter to Issues in the Federally-facilitated Marketplaces, March 14, 2014, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf

[iii] Marion Carter et. al., *Trends in Uninsured Clients Visiting Health Centers Funded by the Title X Family Planning Program — Massachusetts, 2005-2012* (US Government Printing Office: Centers for Disease Control and Prevention (CDC)'s Morbidity and Mortality Weekly Report, January 24, 2014) , http://www.cdc.gov/mmwr/pdf/wk/mm6303.pdf.

[iv] Ibis Reproductive Health and Massachusetts Department of Health, *Low-Income Women's Access to Contraception After Massachusetts Health Care Reform* (Massachusetts: Ibis Reproductive Health and MDPH Family Planning Program, September 2009), http://ibisreproductivehealth.org/work/contraception/documents/Ibis-MDPH_womencontracepMAHCR10-09.pdf.

[v] US Department of Health and Human Services, Center for Consumer Information and Oversight, 2015 Letter to Issues in the Federally-facilitated Marketplaces, March 14, 2014, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf