June 10, 2014

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244

Attn: CMS-9942-NC

Re: Provider Non-discrimination Request for Information

Dear Madam or Sir:

The undersigned organizations are writing in response to the provider non-discrimination request for information 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). We share the concerns raised by the Senate Committee on Appropriations that prompted this inquiry and appreciate the opportunity to submit comments on this important issue.

The Affordable Care Act (ACA) enacted strong protections against the discriminatory practices that have plagued the U.S. health insurance market and restricted access to services and treatments for some of the populations most in need. One of the mechanisms by which some health plans have discouraged individuals, including children, with higher-cost conditions from enrolling in their plans has been to avoid contracting with the essential providers that serve them. As noted by the Senate Committee on Appropriations, we believe the inclusion of section 2706(a) of the Public Health Service (PHSA) was intended to end this type of discrimination. However, the interpretation of section 2706(a) of the PHSA in the April 2013 *Frequently Asked Questions* (FAQ) may allow plans to adjust reimbursement rates for "market standards and considerations" and may leave the door open for this form of discrimination to continue.

Strong and consistent implementation and enforcement of the provider non-discrimination provision in the individual and group health markets in and outside of the Marketplaces is important to create a level playing field across health plans and to sustain a healthy and viable health insurance market. Clear protections are needed to ensure consumers have access to covered services from the full range of providers, including community health centers, safety-net and children's hospitals, HIV/AIDS clinics, and family planning centers, and ensure these providers are offered reimbursement rates that are fair and consistent with similarly-situated providers. With this in mind, we urge HHS, DOL, EBSA and the IRS to:

Clarify that section 2706(a) Must be Met and Bolsters the Impact of the Essential Community Provider Standard in Section 1311(c)(1)(C) of the ACA

Many of the undersigned organizations represent or are served by essential community providers (ECPs)[1] which are designated as such because of the important role that they play

[1] Entities eligible for the federal 340B drug discount program, such as Federally Qualified Health Centers; Ryan White HIV/AIDS Program Providers; Title X family planning clinics; Indian Health Service providers; certain hospitals including children's

caring for medically underserved and low income populations in communities across the U.S. In addition to their willingness to treat a diverse set of patients, ECPs offer a range of vital health services that are not always offered by other providers, including culturally and linguistically competent primary care, behavioral health services, family planning, specialty HIV care and specialized inpatient services. Because ECPs exclusively offer an array of services and serve a distinct set of patients, the ACA recognized their critical role by requiring qualified health plans (QHPs) to include in their networks "essential community providers, where available, that serve predominantly low income, medically underserved individuals." In its 2015 issuer guidance for QHPs to participate in the federally facilitated marketplaces, the Center for Consumer Information and Insurance Oversight (CCIIO) requires QHPs to contract with a minimum of 30% of the ECPs in their service area. In addition, plans are expected to offer ECPs contracts "in good faith" and with "terms that a willing, similarly situated, non-ECP provider would accept or has accepted" to at least one of each ECP type in each county in the service area.[2]

The law is clear that the ECP provision in section 1311 (c)(1)(C) of the ACA and section 2706(a) of the PHSA are two separate standards that QHPs must uphold. To prevent confusion, we urge the Departments to clarify this fact in regulations implementing section 2706(a). These separate, yet equally important, provisions complement each other to help make sure newly-insured consumers in the Marketplaces have access to covered services from the full range of trusted providers in their communities.

Some states also have recognized the important role that ECPs play in meeting the health care needs of low-income and underserved individuals. For example, Connecticut has adopted a high threshold for inclusion of ECPs in QHP networks that all but guarantees full access to needed services. These types of stronger ECP contracting standards are critical if the health care needs of adults and children who require specialized care will be met under the ACA.

Remove Language Allowing Plans to Adjust Reimbursement Rates for "Market Standards and Other Considerations"

We strongly urge the removal of the language allowing rates to be adjusted for "market standards and other considerations" in the FAQ and in any future rule-making to ensure that individuals have access to the providers and services that they need regardless of their income or health condition as intended by the ACA. We agree with the Appropriations Committee that the provider non-discrimination requirement, and we would add the ECP provision, were intended to ensure that patients can access covered services from the full range of provider types in their state. By going beyond the statutory language in section 2706(a), which allows plans to consider quality and performance measures in setting rates, the FAQ may give plans the flexibility to discriminate against certain providers by offering them lower reimbursement rates.

---

hospitals, public hospitals and free-standing cancer hospitals, and other nonprofit health care organizations that meet program criteria.

[2] Centers for Medicare and Medicaid Services. *2015 Letter to Issuers in the Federally-facilitated Marketplaces. March 14, 2014*. Online at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf. Accessed 6.4.14.

Thus far, ECPs have already encountered challenges serving their newly-insured patients during the first year of the ACA with plans employing practices, such as:

- offering below market reimbursement rates to ECPs, including large institutions that play vital role in their communities, serving the uninsured and patients covered by public programs;
- applying tiered cost sharing, including co-insurance, and placing ECP providers on higher cost sharing tiers;
- excluding children's hospitals and essential hospitals from QHP networks, leaving communities without a range of pediatric specialty services and other essential inpatient and outpatient services, including services, such as trauma services, radiation oncology, advanced ophthalmic care, and complex orthopedic care;
- excluding practitioners and physician assistants from plan networks despite their critical role as care providers with certain populations;
- contracting with ECPs only for specialty referrals and offering below market reimbursement rates for that out-of-network care and/or imposing burdensome prior authorization requirements for those referrals; and
- excluding ECP pharmacies from networks.

Protections against these practices are necessary and even more important now that plans are no longer able to control costs by excluding people with pre-existing conditions or rescinding coverage if an individual develops serious and/or chronic conditions. In fact, narrowing their networks by excluding certain providers is one of the few tools that some issuers assert they have to control their rates. Therefore, strong standards and enforcement are necessary to ensure that discrimination does not continue. In addition, QHPs should be encouraged to work with ECPs to coordinate and integrate care as a way to improve quality and control costs rather than arbitrarily limiting their networks.

Thank you very much for accepting comments on this issue. We welcome the opportunity to work with you to ensure that the ACA lives up to its promise of improving access to health care for the millions of Americans who are gaining health insurance coverage because of it.

Respectfully submitted by the following organizations,

America's Essential Hospitals
Association of Asian Pacific Community Health Organizations
Children's Hospital Association
HIV Medicine Association
National Association of Community Health Centers
National Association of Pediatric Nurse Practitioners
National Family Planning & Reproductive Health Association
Planned Parenthood Federation of America
Ryan White Medical Providers Coalition