February 25, 2014

RE: 2015 Draft Letter to Issuers in the Federally-Facilitated Marketplaces

The Honorable Kathleen Sebelius
U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201
By Email: FFEcomments@cms.hhs.gov

Dear Secretary Sebelius:

The undersigned organizations submit these comments on the Draft 2015 Letter to Issuers in the Federally Facilitated Marketplaces ("Letter") released by the U.S. Department of Health and Human Services ("Department") on February 4, 2014. Specifically, we urge the Department to improve the network adequacy and essential community provider ("ECP") standards to ensure that consumers have meaningful access to quality, affordable health care—in keeping with the promise of the Affordable Care Act ("ACA").

Congress designed the ECP protection and the network adequacy provision in the ACA to ensure that individuals purchasing coverage through the marketplaces have access to the trusted providers in their communities, including community health centers, safety net, teaching and children's hospitals, HIV/AIDS clinics, and family planning health centers. When expansions in health insurance coverage are not matched with strong network adequacy protections, Americans are too often left with new coverage options but without access to the providers in their communities or providers with the appropriate experience and expertise to meet their medical needs. This is especially common for providers in medically-underserved communities and providers that care for low income populations with complex, chronic conditions, and for those populations who face cultural barriers or who have limited English proficiency. Section 1311(c)(1)(C) of the ACA was designed to address this challenge head-on by ensuring that essential community providers are included in qualified health plan (QHP) networks—thereby assuring continuity of care and timely access to critical health services.

Unfortunately, many Marketplace plan networks for the 2014 coverage year have left consumers without adequate access to health care providers. We applaud the Department for responding to this issue by proposing improvements to the ECP and network adequacy standards for the 2015 coverage year. Still, we feel that the changes proposed are only incremental improvements over the Department's Letter to Issuers for 2014. There is more work to be done to ensure that in the 2015 plan year, consumers have better access to the providers and the care they need to stay healthy.

Essential Community Providers

We appreciate that the Letter continues to recognize the importance of ensuring access to ECPs. Specifically, we recognize that by proposing to require plans to demonstrate that at least 30 percent of

available ECPs in the service area are included in the QHP issuer's network, the Department has indicated its resolve to increase ECPs' participation in QHP networks. This is a step in the right direction towards improving access to care, especially since ECPs serve as an entry-point into the health care system and as an ongoing source of care for millions of Americans, especially for low-income and medically underserved populations.

However, given the enormous challenges consumers are facing in 2014 as they try to access services from plans with narrow networks, we urge the Department to reconsider the exclusive use of a minimum percentage threshold for ECP contracting. In effect, such a rule exempts QHP issuers from demonstrating that they are in fact providing for "reasonable and timely access to a broad range of [ECPs] for low-income, medically underserved individuals in the QHP's service area," as required by the regulations.[1] The use of a fixed area percentage of ECPs in the service area, in place of a more detailed set of standards taking into account the demographics, geographic and transportation features, and provider mix in each area, is inherently arbitrary. Such an approach is bound to result in inadequate networks in some areas, particularly underserved rural and urban areas. In addition, the use of a fixed minimum percentage of ECPs effectively *invites* QHP issuers to exclude from their networks a subset—and in the case of a thirty percent standard, a sizable majority—of providers that have been deemed "essential" by Congress. We believe this approach is inconsistent with the ACA and the implementing regulation.

If the Department insists on using the same fixed minimum percentage approach that it used for 2014, we urge the Department to consider significantly increasing the 30 percent ECP threshold (e.g. to a threshold in the range of 50%-75% of ECPs in the service area) or, ideally, requiring contracting with any willing ECP, which we believe was Congressional intent. Furthermore, the Department should re-evaluate the standard as more information becomes available about consumer experience with Marketplace plan networks. We also urge the Department to reinforce that the threshold is a federal minimum and encourage plans to include a greater number of ECPs in their networks as a part of ensuring continuity of care.

The Department should also make clear in the final Letter that issuers must include in their networks at least one ECP in each category in each county in the service area, rather than merely offering a contract to one ECP per category per county in order to guarantee access to the full range of services ECPs provide. Additionally, we strongly urge the Department to eliminate the option that permits issuers to forgo the ECP standard by submitting a narrative justification. QHPs should not be permitted to avoid meeting detailed ECP access criteria by using a narrative justification. If the narrative justification is left in place, it should be strengthened to include information about all ECPs that an issuer has reached out to as well as specific information about how the issuer intends to ensure access to timely care for specific populations, including but not limited to those with limited English proficiency, those with chronic or complex medical conditions, and children.

[1] See 45 C.F.R. § 156.235(a).

Furthermore, and consistent with the expectation the Department outlined in the Final Exchange Rule, we urge the Department to clarify that issuers must offer terms that include all of the services the plan covers and offer reimbursement on legally compliant terms. This means that for all ECPs, contracts must be offered in good faith on reasonable terms, including (at minimum) adequate payment and with the recognition that ECPs have a unique patient-mix, and as such, generally applicable rates that are acceptable to non-ECPs may not be adequate for all ECPs. If CMS chooses to retain its proposed approach, the "good faith offer" standard must be strengthened. First, an offer should only be considered to be in "good faith" if it includes a competitive offer of payment for all covered services. Furthermore, the contract must not allow issuer practices that can impede consumers' access to needed care. To ensure that the terms being offered are reasonable and legally compliant, we also recommend that the Department require QHP issuers be required to present the Department with model contracts for each type of ECP provider and that the ECPs in question should be given the opportunity to comment on the issuer's written documentation.

Finally, robust monitoring and enforcement of the ECP standards is just as critical as initial QHP certification. We urge the Department to continue to monitor provider networks throughout the coverage year – taking into account regional differences and consumer complaints – and clarify that the Department may require issuers to broaden QHP networks during the coverage year to ensure enrollees have adequate access to health services.

Network Adequacy

We support the Department's proposal to create a "reasonable access" standard, a federal minimum requirement for network adequacy that would evaluate whether a plan's network provides consumers access to care without unreasonable delay. To strengthen this standard, we urge the Department to incorporate an assessment of appointment wait-times, as well as travel time and distance between providers (and categories of providers). Such an assessment should also evaluate whether a plan's network has the breadth and type of providers to be able to meet the diverse health care needs of consumers. QHPs must have a documented plan to identify access barriers, including wait times, and steps to address those barriers.

In addition, we encourage the Department to clarify that issuers must make an exceptions process available so that consumers can receive needed care at no additional cost from an out-of-network provider if no in-network provider offers a particular covered service, if an in-network provider is not geographically accessible or accessible in a reasonable amount of time, or if an out-of-network provider is able to provide better cultural and linguistic services. Issuers should also, as part of their network adequacy showing, be required to demonstrate that they will satisfy specific legal requirements to cover certain services out of network. Incorporating these elements into the network adequacy standard is critical to ensuring that QHP networks provide consumers with timely access to essential health services and the primary and preventive care they need.

The ECP and network adequacy protections – coupled with the groundbreaking coverage expansions in the ACA – were designed to make sure individuals have timely access to health care. We strongly

support the Department's intention to improve its network adequacy standards and ECP contracting standards. That intention is apparent in the Draft Letter. However, the improvements outlined in the Draft Letter do not go far enough, in our opinion. It is important that the Department strengthen the standards to ensure that consumers are able to access the trusted providers they depend on for quality and timely care.

Respectfully Submitted,

AIDS Action Baltimore
AIDS Foundation of Chicago
American Academy of HIV Medicine
American Association of Medical Colleges
America's Essential Hospitals
Asian & Pacific Islander American Health Forum
Association of Asian Pacific Community Health Organizations
Children's Hospital Association
Clinicians for the Underserved
Community Access National Network
HIV Medicine Association
Maryland Hepatitis Coalition
National Abortion Federation
National Alliance of State & Territorial AIDS Directors
National Association of Community Health Centers
National Council for Behavioral Health
National Council of Asian Pacific Islander Physicians
National Family Planning and Reproductive Health Association
National Hispanic Medical Association
National Minority AIDS Council
National Rural Health Association
National Women's Law Center
Pharmaceutical Access for Community-based Service Providers
Safety Net Hospitals for Pharmaceutical Access
The AIDS Institute