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## **CMS Proposes New Marketplace Network Adequacy Requirements for 2015 under the Affordable Care Act**

Qualified Health Plans (QHPs) participating in Federally-Facilitated Marketplaces (FFMs) or Federally-Facilitated Small Business Health Options Programs (FF-SHOPs) may be required to expand the number of providers in their networks beginning in 2015, according to a [draft letter](#) issued February 4, 2014 by the Centers for Medicare and Medicaid Services (CMS). The changes proposed in the letter would not apply to State-Based Marketplaces like Covered California. The letter, however, references upcoming regulations, suggesting that CMS may also be looking to expand nationwide requirements for all Marketplaces and QHPs.

Responding to criticism from many quarters that some QHP enrollees have faced limited access to in-network providers, CMS's 51 page draft letter proposes steps to strengthen network adequacy requirements for the 2015 benefit year. CMS proposes to apply a "reasonable access" standard when reviewing QHP networks, giving special attention to areas where issues have arisen including hospital systems and primary care, mental health, and oncology providers. QHP issuers will be required to submit a provider list that includes all in-network providers and facilities for all plans for which a QHP certification application is submitted.

If CMS determines that a network fails to meet the "reasonable access" standard, CMS proposes notifying the applicant of the problem area(s) and considering the applicant's response in determining if regulatory requirements have been met.

While the letter does not adopt specific time and distance standards for network adequacy, CMS suggests that it intends to use the review process to inform the development of specific standards (including time and distance requirements) for FFM QHP networks in future rulemaking. CMS's proposed implementation of a reasonable access standard and indication of potential future rulemaking on network adequacy standards are welcome signs for providers and patient advocates. For the 2014 benefit year, CMS largely deferred to state network adequacy reviews and generally did not use its certification authority to assure network adequacy of QHPs on FFMs.

The letter also proposes heightening essential community provider (ECP) network participation requirements in future rule making. ECPs include providers that serve predominantly low-income and medically underserved individuals, and specifically include 340B providers and other tax exempt providers that do not satisfy the federal funding

requirement for 340B providers but otherwise satisfy 340B criteria. The proposed ECP standard would require that each QHP contract with at least 30 percent of the available ECPs in its service area. (For the 2014 benefit year, QHPs on FFMs were only required to satisfy a 20 percent contracting requirement for ECPs or submit a narrative justification explaining how the plan nonetheless complied with the ECP requirement.) ECPs in the hospital category include disproportionate share hospitals, rural referral centers, children's hospitals, sole community hospitals, freestanding cancer centers and critical access hospitals. CMS has published a non-exhaustive list of ECPs on its CCIIO website. Plans can also write in other ECPs provided that they satisfy certain requirements.

For plans that do not meet the 30 percent requirement, CMS proposes a requirement that the plan outline how it will meet the needs of low-income and medically underserved members. These plans must also provide the number of contract offers made to ECPs for the 2015 benefit year, the number of additional contract offers expected and the timeframe for negotiations, the names of ECP hospitals and federally qualified health centers (FQHCs) that have been offered contracts that are still under consideration, and contingency plans for how the plan will provide adequate care to enrollees if there are not enough ECPs in the plan.

The letter also proposes that all QHPs must have offered contracts in good faith prior to the benefit year to (1) all available Indian health providers in the service area; and (2) at least one ECP in each ECP category in each county in the service area, where an ECP is available. The six ECP categories include hospitals and FQHCs. To be offered in good faith, contracts offered must contain terms that a "willing, similarly-situated, non-ECP provider would accept or has accepted."

The letter also proposes other standards and requirements that suggest increased plan oversight in the coming years. The letter specifically addresses issues with QHPs' provider directories, proposing that provider directories should be up to date and readily accessible from a website that clearly identifies the directory applicable to each QHP and does not require a log-in or navigation of the plan's website. During the 2014 open enrollment period, the accessibility of provider directories has varied widely between QHPs, impeding the ability of consumers to make more informed plan choices.

The deadline for comments is February 25, 2014. Comment should be submitted to [FFEcomments@cms.hhs.gov](mailto:FFEcomments@cms.hhs.gov).

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