

**Supporting Statement for Essential Community Provider Data Collection  
to Support QHP Certification for PY 2017  
(OMB Control No. 0938-NEW)**

**A. Background**

In accordance with section 1311(c)(1)(C) of the Affordable Care Act (ACA), Qualified Health Plan (QHP), including Stand-alone Dental Plan (SADP) issuers are required to include within their network essential community providers (ECPs), where available, that serve predominantly low-income, medically-underserved individuals. Under this same section of the ACA, the Secretary of the Department of Health and Human Services (HHS) is charged with establishing criteria for certification of health plans as QHPs, including criteria for issuer satisfaction of the ECP inclusion requirement. Under 45 Code of Federal Regulations (CFR) 156.235, the Secretary of HHS has established criteria for inclusion of a sufficient number and geographic distribution of ECPs, where available, in an issuer's network to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in their service areas. To satisfy this ECP requirement, QHP and SADP issuers must submit an ECP template as part of their QHP application, in which they must list the ECPs with whom they have contracted to provide health care services to low-income, medically underserved individuals in their service areas.

The HHS has compiled a non-exhaustive list of available ECPs, based on data it and other Federal partners maintain, which has been used as an initial source of ECP information. The non-exhaustive HHS ECP list for the 2016 benefit year is available at <http://cciio.cms.gov/programs/exchanges/qhp.html>. HHS updates this ECP list annually to assist issuers with identifying providers that qualify for inclusion in an issuer's plan network toward satisfaction of the ECP standard under 45 CFR 156.235. Under that regulation, ECPs are defined as health care providers who serve predominantly low-income, medically underserved individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service (PHS) Act and described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act (SSA).

The HHS ECP list for the 2016 benefit year contains the following provider types:<sup>1</sup>

- Federally Qualified Health Centers (FQHCs) and FQHC look-alikes.
- Ryan White HIV/AIDS Program providers.
- Health centers providing dental services, including all of the above organizations that have noted to Health Resources and Services Administration (HRSA) that they provide dental services in their scope of project.
- Hospitals: Critical Access Hospitals, Rural Referral Centers, Disproportionate Share (DSH) and DSH-eligible Hospitals, Children's Hospitals, Sole Community Hospitals, Freestanding Cancer Centers.
- Sexually Transmitted Disease Clinics, Tuberculosis Clinics, Hemophilia Treatment

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<sup>1</sup> The providers on the HHS ECP list for the 2016 benefit year were provided to HHS primarily by the Health Resources and Services Administration, the Indian Health Service, and the Office of the Assistant Secretary for Health/Office of Population Affairs as qualifying to be classified as one of these provider types.

Centers, and Black Lung Clinics.

- Rural Health Clinics: a Medicare-certified Rural Health Clinic is included in the non-exhaustive ECP list if it meets the following two requirements: 1) Based on attestation, it accepts patients regardless of ability to pay and offers a sliding fee schedule; or is located in a primary care Health Professional Shortage Area (HPSA) (geographic, population, or automatic<sup>2</sup>); and 2) Accepts patients regardless of coverage source (i.e., Medicare, Medicaid, CHIP, private health insurance, etc.).
- Family planning providers receiving grants under Title X of the PHS Act and not-for-profit or governmental family planning service sites that do not receive a grant under Title X of the PHS Act.
- Indian Health Providers: Tribes, Tribal Organization and Urban Indian Organization providers, and Indian Health Service Facilities.

For the Federal Register Notice published on June 5, 2015, we received 17 public comments and have provided summaries of these comments and our responses in the supporting document titled “Comment Summaries in Response to Paperwork Reduction Act Notice Published June 5, 2015.”

## **B. Justification**

### **1. Need and legal basis**

#### **Provider Information Collection**

Standards for ECP requirements are codified at 45 CFR 156.235. Issuers must contract with at least 30 percent of the available ECPs in the plan’s service area. Currently, issuers rely on the non-exhaustive HHS list of available ECPs to identify qualified ECPs that can be counted toward an issuer’s satisfaction of the 30 percent ECP standard, along with qualified ECPs that an issuer writes in on their ECP template as part of their QHP application. The majority of issuers have relied more heavily on ECP write-ins than on ECPs from the HHS list to satisfy the 30 percent standard. Because an issuer’s ECP write-ins count toward satisfaction of the ECP standard for only the issuer that writes in the ECP on their ECP template, this methodology for calculating the available ECPs has resulted in a variation of the available identified ECPs for a given service area based on the number of ECP write-ins a specific issuer includes on their ECP template.

To ensure that the HHS ECP list more accurately reflects the universe of qualified available ECPs in a given service area, HHS will collect more complete data from such providers so that all issuers are held to a more uniform ECP standard. The HHS aims to achieve this outcome by

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<sup>2</sup> As of January 1, 2014, more than 1,000 Rural Health Clinics (RHCs) were designated as an automatic Health Professional Shortage Area (HPSA), the criteria for which include accepting patients regardless of ability to pay; offering a sliding fee schedule based on ability to pay (income); and accepting Medicare, Medicaid, CHIP, and private health insurance patients. To receive the automatic HPSA designation, each RHC is required to complete an attestation form, which is available here: <http://bhpr.hrsa.gov/shortage/hpsas/certofeligibility.pdf>. RHCs that are not listed on the current HHS ECP list and complete the attestation form to receive an automatic HPSA designation through the Health Resources and Services Administration will be considered for inclusion on future HHS ECP lists. More information about the HPSA designation requirements and process is also available here: <http://bhpr.hrsa.gov/shortage/hpsas/ruralhealthhpsa.html>.

soliciting qualified ECPs to complete and submit the ECP provider petition in order to be added to the HHS ECP list or address required missing data fields to remain on the list, resulting in a more robust listing of the universe of available ECPs from which issuers select to satisfy the 30 percent ECP standard. The degree of provider participation in this data collection effort through the ECP provider petition will help inform HHS's future proposals for counting issuers' ECP write-ins toward satisfaction of the ECP standard.

In order to most effectively achieve the ECP operational improvements described above, HHS will collect such data directly from providers through the ECP provider petition (see Appendix A). The HHS will not be accepting petitions from third-party entities on behalf of the provider about which the petitioner is requesting the addition or correction for the ECP list. Third-party entities include issuers, advocacy groups, State departments of health, State-based provider associations, and providers other than the provider about which the petition is applicable. However, if any of the above entities own or are the authorized legal representatives of an ECP, then they may submit a petition on behalf of a provider. For example, a local health department that operates its own family planning clinics may appropriately petition for those clinics. In contrast, a State department of health should not attempt to correct ECP listings based on its own database of similar providers.

Collection of the data directly from such providers will better ensure the integrity of the data to support issuers as they apply for QHP certification and recertification, build a more robust HHS ECP listing of the universe of available ECPs, and support HHS's QHP compliance monitoring on an ongoing basis. Feedback about the ECP petition will be collected from stakeholders in an effort to improve the efficiency and value of the data collection.

### **Necessary Data for Provider Petition Submission**

The HHS will collect the provider data elements as displayed in Appendix A (i.e., the ECP Provider Petition). Providers are asked to confirm the accuracy of their provider data that appear on the draft 2017 HHS ECP list and complete any required missing data fields, or provide such data if petitioning to be newly added to the list.

In addition, qualified provider petitioners must be MDs, DOs, DDDs, PAs, or NPs authorized by the State to independently treat and prescribe within the listed facility and must attest to the following statements within the petition:

- Provider consents to be added to or remain on the HHS ECP list for the 2017 benefit year.
- Provider is either A) eligible for or participating in the 340B program or is a Rural Health Clinic or is an Indian Health Care Provider; or B) located in a low-income ZIP code or HPSA<sup>3</sup>, unless the provider has been included in one of the verified datasets from HRSA, the Indian Health Service (IHS), or the Office of the Assistant Secretary for Health/Office of Population Affairs (OASH/OPA), and appears on the Draft 2017 ECP List.

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<sup>3</sup> Based on the HHS Low-Income and Health Professional Shortage Area (HPSA) ZIP Code Listing," available at <http://www.cms.gov/ccio/programs-and-initiatives/health-insurance-marketplaces/qhp.html>.

- Provider accepts patients regardless of ability to pay and offers a sliding fee schedule, unless the provider has been included in one of the verified datasets from HRSA, IHS, or OASH/OPA and appears on the Draft 2017 ECP List.
- Provider accepts patients regardless of coverage source (i.e., Medicare, Medicaid, CHIP, private health insurance, etc.).
- Provider agrees to be listed in a consumer-facing directory of ECPs.
- List the number of FTE medical and dental practitioners at the given facility.
- List the number of executed contracts and good faith contract offers rejected.

## 2. **Purposes and Use of Information Collection**

The purpose of the ECP provider petition is for HHS to achieve the following:

- For providers that are not on the draft 2017 HHS ECP list,
  - Collect information to determine whether a provider requesting to be added to the ECP list for the 2017 benefit year meets the definition of an ECP under 45 CFR 156.235.
- For providers that are on the draft 2017 HHS ECP list,
  - Allow providers an opportunity to update their provider data prior to publication of the draft HHS ECP list for the 2017 benefit year, as required by HHS;
  - Collect missing data from critical data fields on the HHS ECP list, such as the National Provider Identifiers (NPIs), points of contact (POCs), and the number of MDs, DOs, PAs, NPs, DMDs, and DDSs authorized by the State to independently treat and prescribe within the listed facility; and
  - Obtain confirmation from providers that they are aware that they are on the list and elect to remain on the HHS ECP list for the 2017 benefit year.

The HHS ECP list for the 2016 benefit year is not exhaustive and does not include every provider that participates or is eligible to participate in the 340B drug program, every provider that is described under section 1927(c)(c)(1)(D)(i)(IV) of the Social Security Act, or every provider that might otherwise qualify under the regulatory standard at 45 CFR 156.235. For the 2017 benefit year, HHS will review provider petitions for inclusion on the HHS ECP list in an effort to build a more robust HHS ECP listing of the universe of available ECPs from which issuers select to satisfy the 30 percent ECP standard for a given service area. Additionally, issuers may use the points of contacts on the ECP list to aid in provider network development. The degree of provider participation in this data collection effort through the ECP provider petition will also help inform HHS's future proposals pertaining to the ECP write-in process.

## 3. **Use of Improved Information Technology and Provider Burden Reduction**

The HHS coordinates closely with HRSA, IHS, and OASH/OPA to update the HHS ECP list annually and review requested corrections and additions received directly from providers. While we have verified the status of the providers that appear on the HHS ECP list, many of the provider datasets received from HRSA, IHS, and OASH/OPA are missing data elements critical for issuers to identify such providers for contract offerings. The HHS has designed the ECP

petition process as a mechanism to reduce provider burden with respect to submitting and updating their data for inclusion on the HHS ECP list. Provider must complete required missing data fields in order to be added to or remain on the final 2017 HHS ECP list.

The HHS will accept provider petitions in only the required format to ensure the integrity of the provider data received and to reduce the burden on providers to provide their data. The required format lowers the burden on providers by virtue of interactive programming logic that imports provider data from the draft 2017 HHS ECP list for providers that already appear on the list and by graying out non-applicable data fields based on the provider's selections. The required format includes provider completion of all required data fields and will generate error messages that provide guidance to the petitioner on how to resolve any identified errors or incomplete data fields to assist the petitioner with validating and submitting the petition to HHS. Detailed instructions for completing each column appear within the petition as the petitioner places the cursor over each column header.

#### **4. Efforts to Identify Duplication and Use of Similar Information**

The HHS has worked closely with HRSA, IHS, and OASH/OPA to collect and verify available provider data in the HHS ECP list. Providers that appear are on the draft 2017 HHS ECP list are asked to enter the row number from the draft 2017 HHS ECP list. The provider petition is then programmed to import the provider data from the draft 2017 HHS ECP list into the provider petition to eliminate duplication of efforts by the provider. Providers are asked to confirm the accuracy of their provider data that appear on the draft 2017 HHS ECP list and complete any required missing data fields, or provide such data if petitioning to be newly added to the list. The data collected via the provider petition will reduce issuer and provider burden by building a more complete and accurate listing of ECPs from which issuers select to satisfy the 30 percent ECP standard.

#### **5. Impact on Small Businesses**

We do not anticipate that small businesses will be significantly burdened by this data collection. Many of the small business providers who complete the petition will benefit from the increased accuracy of their data appearing on the HHS ECP list.

#### **6. Less Frequent Collection**

The burden associated with this information collection consists of providers either updating their ECP data to remain on the HHS ECP list or providing the required data to be newly added to the HHS ECP list. Since provider demographics and provider contracts with issuers change on an ongoing basis, HHS requires QHP issuers to report their ECP contracts annually via the ECP template to ensure the accuracy of their provider network data, so HHS anticipates collecting this provider data on annual basis. The year two and three burden estimates include estimates for renewing providers and newly petitioning providers. In future years beyond the 2017 benefit year, we anticipate offering renewing providers a streamlined option for attesting to no changes needed to previous ECP attestations and ECP data, as applicable to the provider. We will continue to reassess the provider petition burden and make every effort to further minimize provider burden in the future.

**7. Special Circumstances**

There are no anticipated special circumstances.

**8. Federal Register/Outside Consultation**

As required by the Paperwork Reduction Act of 1995 (44 U.S.C.2506 (c)(2)(A)), CCIIO will publish a 30-day notice in the Federal Register soliciting public comment on its proposed information collection requirements.

The goal of this data collection is to inform the QHP certification and recertification process by developing an ECP provider petition that improves the accuracy of the HHS ECP list and simplifies issuer reporting of ECPs included in their networks via the ECP template. Throughout the first two years of certification activities, HHS has received extensive feedback from key stakeholders regarding improving the accuracy of the HHS ECP list. These discussions have included webinars and user group calls with providers, provider associations, States, issuers, issuer associations, and Federal partners on strategies to improve the accuracy of the HHS ECP list and simplifying issuer reporting of ECPs included in their networks. It is the goal of HHS and stakeholders to identify ways to continually improve the validity of the ECP data. The HHS will continue to work with key stakeholders to minimize any required data submission to streamline and reduce duplication.

**9. Payments/Gifts to Respondents**

No payments and/or gifts will be provided.

**10. Confidentiality**

There are no confidentiality issues with this collection.

**11. Sensitive Questions**

No sensitive questions are included in these notice requirements.

**12. Burden Estimates (Hours & Wages)**

The burden associated with this data collection is estimated to be 23,920 burden hours for providers in total for year one. We developed this burden estimate based on the number of providers appearing on the HHS ECP list for the 2016 benefit year, as well as HHS's experience collecting similar data from providers submitting comments to our draft HHS ECP list for the 2016 benefit year. We have adjusted the burden to account for feedback on the ECP list development process from HRSA, IHS, and OASH/OPA.

We developed the provider burden estimates for years 2 and 3 based on the average 15 percent increase in providers listed on the HHS ECP list over the past two certification years, in addition to the expectation that additional providers will petition in future years.

The following section of this document contains an estimate of the burden imposed by the associated information collection requirements (ICRs). Salaries for the positions cited were completely taken from the Bureau of Labor Statistics (BLS) website (<http://www.bls.gov/bls/blswage.htm>).

We estimate that in the first year, it will take 1 hour per year for a provider to complete and submit the ECP provider petition, which consists of confirming the accuracy of their provider data that appear on the draft 2017 HHS ECP list or provide such data for providers petitioning to be newly added to the list, consent to remain on the HHS ECP list for the 2017 benefit year, and complete any missing required data fields.

We estimate that 23,920 providers will be subject to this requirement for year one. On average, in the first year, we estimate that it will take a provider 1 hour (at \$26 an hour<sup>4</sup>) to complete and submit the ECP provider petition. The total estimated burden is \$26 per year for each petitioning provider or \$621,920 for all providers in year one.

In years two and three, we estimate that it will take 30 minutes (at \$26 an hour) for a renewing provider to complete and submit the ECP provider petition and one hour (at \$26 an hour) for a provider petitioning to be newly added to the HHS ECP list. The increased burden in the first year accounts for initial time providers may need to become familiar with the ECP provider petition attestations and required data fields. We estimate that the increase in the percentage of providers petitioning to be added each year will be 15 percent.

Based on these estimates, the cost burden for renewing providers is estimated to be \$13 (including fringe benefits) for each provider and the cost burden for providers petitioning to be newly added to the HHS ECP list is estimated to be \$26 for each provider for years two and three. For year two, HHS estimates a total of 23,920 renewing providers and 3,588 providers petitioning to be newly added to the HHS ECP list, totaling \$310,960 for renewing providers and \$93,288 for providers petitioning to be newly added to the HHS ECP list. For year three, HHS estimates a total of 27,508 renewing providers and 4,126 providers petitioning to be newly added to the HHS ECP list, totaling \$357,604 for renewing providers and \$107,276 for providers petitioning to be newly added to the HHS ECP list.

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<sup>4</sup>Employment rates determined by the national estimates for the occupational employment and wages, May 2014 at <http://www.bls.gov/oes/current/oes431011.htm>. At the time of this publication, the 2015 National Occupational Employment and Wage Estimates were not yet available from the Bureau of Labor Statistics.

**Table 1: Burden to Providers**

<b>Year</b>	<b>Labor Category</b>	<b>Hourly Labor Costs (Hourly rate + 35% Fringe benefits)</b>	<b>Burden Hours</b>	<b>Total Cost per Provider</b>	<b>Total Number of Providers</b>	<b>Total Annual Cost for all Providers</b>
One	Administrative Support Supervisor	\$26	1 (renewals); 1 (new adds)	\$26 (renewals); \$26 (new adds)	20,800 (renewals); 3,120 (new adds)	\$621,920 (renewals and adds)
Two	Administrative Support Supervisor	\$26	0.5 (renewals); 1 (new adds)	\$13 (renewals); \$26 (new adds)	23,920 (renewals); 3,588 (new adds)	\$310,960 (renewals); \$93,288 (new adds)
Three	Administrative Support Supervisor	\$26	0.5 (renewals); 1 (new adds)	\$13 (renewals); \$26 (new adds)	27,508 (renewals); 4,126 (new adds)	\$357,604 (renewals); \$107,276 (new adds)
<b>Total Burden for 3 years</b>			<b>53,491 hours</b>		<b>31, 634 providers</b>	<b>\$1,491,048</b>

**13. Capital Costs**

There are no additional capital costs.

**14. Cost to Federal Government**

For year one, we estimate that the operations and maintenance costs to the Federal government for the ECP provider petition (i.e., the collection instrument) will be \$325,000 in contractor support and \$50,000 in HHS staff resources for a total cost of \$375,000. These estimates include costs associated with design and implementation of the provider petition process and generation of the final 2017 HHS ECP list by importing provider data collected from the ECP provider petitions. These estimates are based in part on HHS’s costs incurred to generate the 2016 HHS ECP list.

For years two and three, we estimate that the cost to the Federal government will decrease by \$150,000 compared to year one, as a result of no contractor support being needed for provider petition design. Therefore, for years two and three, we estimate that the total cost per year to the Federal Government for the operations and maintenance of the ECP provider petition will be \$225,000.



**15. Changes in Burden**

There are no changes in the burden. This is a new collection requirement.

**16. Publication/Tabulation Dates**

The information collection from providers is anticipated under this request to occur in the fourth quarter of 2015. We will collect this provider data annually and make a portion of the data public via the update to the HHS ECP list that is published annually on our CCIIO website.

**17. Expiration Date**

The HHS has no objections to displaying the expiration date.