



## Appendix A:

### Instructions for the Essential Community Providers Provider Petition for the 2023 Plan Year

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The below instructions will be displayed at the following petition link:  
[https://data.healthcare.gov/ccio/ecp\\_petition](https://data.healthcare.gov/ccio/ecp_petition)

### Petition for the 2023 Plan Year

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The ECP List currently displayed on this website is the rolling draft Plan Year 2023 ECP List, updated monthly to include recently approved provider petitions. This ECP List can be viewed by clicking "Check to see if you are on the list" under question 6 of the petition.

For ongoing provider updates, the ECP petition submission process remains open year-round. Provider petitions submitted between August 27, 2020 and August 18, 2021, will be reviewed for inclusion on the final Plan Year 2023 ECP List. Provider petitions submitted after August 18, 2021, will be reviewed for inclusion on the final Plan Year 2024 ECP List.

### 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,

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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 Department of Health and Human Services (HHS) has compiled a non-exhaustive final list of available ECPs for plan year (PY) 2022. These providers submitted an ECP petition to be added to the ECP List or update their existing data on the list and were approved by CMS through the ECP petition review process. 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; entities described in section 1927(c)(1)(D)(IV) of the Social Security Act (SSA), including State-owned family planning service sites, governmental family planning service sites, not-for-profit family planning service sites that do not receive Federal funding under special programs, including under Title X of the PHS Act or other 340B-qualifying funding; or Indian health care providers, unless any of the above providers has lost its status under either of these sections, 340(B) of the PHS Act or 1927 of the Act, as a result of violating Federal law.

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## Instructions

For clarifications regarding specific questions within the ECP petition, place your cursor over the information icon that follows each question and additional information will appear in a pop-up window. If you are experiencing issues with entering data into or submitting the form, try using one of the supported browsers: Google Chrome, Apple Safari, and Mozilla Firefox, and the most recent version of Microsoft Edge and Internet Explorer 11. If you need help beyond the tips provided here, you may reach us via email at [essentialcommunityproviders@cms.hhs.gov](mailto:essentialcommunityproviders@cms.hhs.gov).

### ***Complete the following data fields within the Petition Form:***

#### ABOUT YOU

- *“Full name of person completing this Provider Petition.”* [Required field.] The data that you enter in this field will auto-populate POC 1 Name field. You may change the auto-populated data in the POC 1 Name field if it differs from the individual completing this provider petition.
- *“Phone # of person completing Provider Petition.”* [Required field.] If you seek to add a record, the data that you enter in this field will auto-populate POC 1 Name field. You may change the auto-populated data in the POC 1 Name field if it differs from the individual completing this provider petition.
- *“Phone Ext of person completing Provider Petition.”* [Required field.] If you seek to add a record, the data that you enter in this field will auto-populate POC 1 Phone Ext field. You may change the auto-populated data in the POC 1 Phone Ext field if it differs from the phone extension for the individual completing this provider petition.
- *“Email address of person completing Provider Petition.”* [Required field.] If you seek to add a record, the data that you enter in this field will auto-populate POC 1 Email field. You may change the auto-populated data in the POC 1 Email field if it differs from the email for the individual completing this provider petition.
- *“I am the Listed Provider or otherwise authorized to submit this request on behalf of the Facility. Please check box to indicate agreement.”* ☐ [Required field.] Qualified petitioners include providers petitioning to make a change to their own HHS ECP listing, providers petitioning to be added to or removed from the HHS ECP List, or individuals

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explicitly authorized by the provider to submit the petition on behalf of the provider. CMS is not accepting petitions from unauthorized third-party entities, including issuers, advocacy groups, state Departments of Health, state-based provider associations, and providers other than the provider that is the subject of the petition. However, if any one of the above entities owns or is the authorized legal representative of an ECP, it may submit a petition on behalf of a provider.

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## REQUESTED ACTION

- *“My facility consents to be added to or remain on the HHS ECP List for the purpose of receiving contract offers from Marketplace Qualified Health Plan Issuers. Please check box to indicate agreement.”* ☐ [Required field.]  
If you do not yet appear on the HHS ECP list and do not consent to be added to the list, then you should not submit this provider petition. If you currently appear on the HHS ECP List and do not consent to remain on the list, then you should submit a removal petition to ensure that your data are removed from the HHS ECP List.
- *“To ensure that my facility maintains its ongoing status on the HHS ECP List, my facility agrees to visit this petition site each year for the purpose of responding to newly added questions and updating its provider information (e.g., changes to contact information, provider services, etc.). Please check box to indicate agreement.”* ☐ [Required field.]
- *“My facility agrees to be listed in a consumer-facing directory of ECPs.” Please check box to indicate agreement.”* ☐ [Required field.]  
Checking this box indicates that you are willing to be listed in a consumer-facing directory of ECPs by an issuer with whom you have contracted to deliver health care services to their enrollees. CMS will continue to post the HHS ECP list on our publicly available website as a resource for QHP issuers and consumers seeking providers who are willing to serve low-income and medically underserved populations.  
Selecting No to this question means that you do not qualify as an ECP for purposes of being added to the ECP list. If you already appear on the HHS ECP List that was published with this petition, then you should submit a removal petition to ensure that your data are removed from the HHS ECP list. “
- *“Are you petitioning to add your facility to the ECP list, change/update or add missing data to your facility row that already appears on the ECP list, or remove your facility from the list?”* [Required field.]

Select Add if you wish to be newly added to the HHS ECP List, including additional provider site locations. Affiliated practitioners located at same street location will appear only once on the ECP List, so please list the facility rather than individual practitioners located at same facility, indicating the number of qualified FTE practitioners available at the facility within the FTE questions that follow. Solo practitioners may submit the petition under their individual provider location.

Select Change if you are a provider that already appears on the HHS ECP List and you wish to change/update or add missing required data (e.g., NPI, POCs, FTEs) to your facility row. If you are unsure of whether you appear on the HHS ECP List, click the button labeled “Check to see if you are on the list” and enter your site name using the search functionality to identify your ECP Reference Number. Note that the ECP Reference Number for each

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facility on the ECP list appears in column A titled “ECP Reference Number” of the Excel spreadsheet, rather than referring to the electronic row number assigned by Excel.

Select Remove if you wish to be removed from the HHS ECP List. If you are requesting to be removed, please enter your row number in the following question from the HHS ECP List embedded within this petition by clicking the button labeled “Check to see if you are on the list” and entering your site name using the search functionality. Note that the ECP Reference Number for each facility on the ECP list appears in column A titled “ECP Reference Number” of the Excel spreadsheet, rather than referring to the electronic row number assigned by Excel.

Please note that if you return to this question to revise your selection, any data that you have entered for the questions that follow will be deleted.

- “ECP Reference Number (Please do not include commas or spaces.) [Click here after entering ECP Reference Number.]” [Required field if already on the list and changing/updating your provider data.]

If you are a provider that already appears on the HHS ECP List published with this petition, please identify the correct ECP Reference Number on which your facility is listed by clicking the button labeled “Check to see if you are on the list” and entering your site name using the search functionality. Note that the ECP Reference Number for each facility on the ECP list appears in column A titled “ECP Reference Number” of the Excel spreadsheet, rather than referring to the electronic row number assigned by Excel. Enter your ECP Reference Number and click elsewhere on the screen, and the petition will auto-populate many of the data fields that currently appear on the HHS ECP List. Please do not include commas or spaces in your ECP Reference Number, only numbers. Check that the auto-populated data from the HHS ECP List are correct, correct any errors, and provide missing data fields (e.g., ECP Categories, FTE counts, opioid treatment services, telehealth questions, etc.) by proceeding through the petition. If the ECP Reference Number field does not appear, you have selected Add in the above question, indicating that you do not appear on the HHS ECP List and are petitioning to be newly added to the list, so this ECP Reference Number field would not be applicable.

## ELIGIBILITY

- “Are you one of the following types of providers: (1) eligible for or participating in the 340B program; (2) a Rural Health Clinic; (3) an Indian health care provider; or (4) a State-owned family planning service site, governmental family planning service site, or not-for-profit family planning service site that does not receive Federal funding under special programs, including under Title X of the PHS Act or other 340B-qualifying funding?” [Required field.]

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Select Yes if you are one of the following types of providers: (1) eligible for or participating in the 340B program; (2) a Rural Health Clinic; (3) an Indian health care provider; or (4) a State-owned family planning service site, governmental family planning service site, or not-for-profit family planning service site that does not receive Federal funding under special programs, including under Title X of the PHS Act or other 340B-qualifying funding. For a complete list of organizations that are eligible for the 340B program, see

<http://www.hrsa.gov/opa/eligibilityandregistration/index.html>. Select No if you are not one of the following types of providers: (1) eligible for or participating in the 340B program; (2) a Rural Health Clinic; (3) an Indian health care provider; or (4) a State-owned family planning service site, governmental family planning service site, or not-for-profit family planning service site that does not receive Federal funding under special programs, including under Title X of the PHS Act or other 340B-qualifying funding.

- “Are you located in a low-income ZIP code or geographic HPSA?” [Required field.]

Select Yes only if you are located in a low-income ZIP code or geographic Health Professional Shortage Area (HPSA), based on the HHS “Low-Income and HPSA ZIP Code Listings” available at

<https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>. Selecting No to this question means that you do not qualify as an ECP for purposes of being added to the ECP list, unless you are one of the following types of providers: (1) eligible for or participating in the 340B program; (2) a Rural Health Clinic; (3) an Indian health care provider; or (4) a State-owned family planning service site, governmental family planning service site, or not-for-profit family planning service site that does not receive Federal funding under special programs, including under Title X of the PHS Act or other 340B-qualifying funding.

- “Has your facility received a HPSA designation?” [Required field.]

Yes ☐ If yes, please enter your 10-digit HPSA ID here: \_\_\_\_\_.

No ☐

If you select Yes, enter your 10-digit HPSA ID for validation against the HPSA database managed by the Health Resources and Services Administration located at

<https://data.hrsa.gov/tools/shortage-area/hpsa-find>.

- “Do you agree to accept patients regardless of ability to pay and offer a sliding fee schedule?” [Required field.]

Select Yes only if you are willing to accept patients regardless of ability to pay and offer a sliding fee schedule. Selecting No to this question means that you do not qualify as an ECP for purposes of being added to the HHS ECP list, unless you are one of the following types of providers: (1) eligible for or participating in the 340B program; (2) a Rural Health Clinic; (3) an Indian health care provider; or (4) a State-owned family planning service site, governmental family planning service site, or not-for-profit family planning service site that does not receive Federal funding under special programs, including under Title X of the

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PHS Act or other 340B-qualifying funding.

- *“Do you agree to accept patients regardless of coverage source (i.e., Medicare, Medicaid, CHIP, private health insurance, etc.)?”* [Required field.]  
Select Yes only if you are willing to accept patients regardless of coverage source (i.e., Medicare, Medicaid, CHIP, private health insurance, etc.).  
Selecting No to this question means that you do not qualify as an ECP for purposes of being added to the HHS ECP list. If you already appear on the HHS ECP List that was published with this petition, then you should submit a removal petition to ensure that your data are removed from the HHS ECP list.
- *“Is the facility an inpatient hospital or a children’s inpatient hospital? If yes, please enter the number of staffed hospital beds?”* [Required field.]  
For inpatient hospitals, including children’s hospitals, please indicate the number of staffed hospital beds. If the facility is not an inpatient hospital or children’s inpatient hospital, please enter 0.
- *“If the facility is not an inpatient hospital or children’s inpatient hospital, please enter the number of FTEs representing MDs, DOs, PAs, NPs authorized by the state to independently treat and prescribe medication within the listed facility? For inpatient hospitals, including children’s hospitals, please enter 0.”* [Required field.]  
For inpatient hospitals, including children’s hospitals, please enter 0. For all other ECP categories, please enter number of FTEs representing MDs, DOs, PAs and NPs authorized by the State to independently treat and prescribe medication within the listed facility at this street location, as of the date of your petition submission. Two part-time practitioners can be counted as one FTE and fractional FTEs up to two decimal places can be reported (e.g., 0.75). Multiple affiliated MDs, DOs, PAs and NPs practicing within the same provider facility located at the same street location (regardless of different suite/floor number) will appear on one row on the HHS ECP List, so please list the facility and indicate number of affiliated FTE practitioners located at the facility rather than submitting a petition for each individual practitioner. Also, practitioners who practice within a multi-practitioner facility should not submit a petition under their individual practitioner NPI independent of the facility in which they practice; rather, only individuals authorized by the facility should submit the petition using the facility-level NPI and indicate the number of affiliated FTE practitioners practicing within the facility. Multi-practitioner facilities with multiple locations should submit a petition for each site location, entering the NPI associated with each of its facility-specific site locations, and indicating the number of affiliated FTE practitioners practicing only within the facility-specific site location. In contrast, solo practitioners may submit the petition under their individual practitioner NPI. If you have only dentists (DMDs and DDSs) at this facility, please enter zero in this field.
- *“If the facility is not an inpatient hospital or children’s inpatient hospital, please enter the number of FTEs representing DMDs and DDSs authorized by the state to independently*

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*treat and prescribe medication within the listed facility? For inpatient hospitals, including children's hospitals, please enter 0.*" [Required field.]

For inpatient hospitals, including children's hospitals, please enter 0. For all other ECP categories, please enter number of FTEs representing DMDs and DDSs practicing at your facility at this street location, as of the date of your petition submission. Two part-time practitioners can be counted as one FTE and fractional FTEs up to two decimal places can be reported (e.g., 0.75). Multiple affiliated dentists practicing within the same provider facility located at the same street location (regardless of different suite number) will appear on one row on the HHS ECP List, so please list the facility and indicate number of affiliated FTE dentists located at the facility rather than submitting a petition for each individual dentist. Also, dentists who practice within a multi-practitioner facility should not submit a petition under their individual practitioner NPI independent of the facility in which they practice; rather, only individuals authorized by the facility should submit the petition using the facility-level NPI and indicate the number of affiliated FTE dentists practicing within the facility. Multi-practitioner facilities with multiple locations should submit a petition for each site location, entering the NPI associated with each of its facility-specific site locations, and indicating the number of affiliated FTE dentists practicing only within the facility-specific site location. In contrast, solo practitioners may submit the petition under their individual practitioner NPI. If you have only medical practitioners (MDs, DOs, PAs and NPs) at this facility, please enter zero in this field.

- *"Number of contracts executed with QHP insurance companies (i.e., issuers)?"* [Required field.] Enter the number of contracts that you have executed with QHP insurance companies (i.e., issuers) that you expect to continue for the upcoming plan year.
- *"Number of contract offers received from QHP insurance companies (i.e., issuers) that you have rejected?"* [Required field.]

Enter the number of contract offers that you have received from QHP issuers and were offered in good faith that you have rejected for the upcoming plan year, as of the date of your petition submission. As stated in the Final 2017 Letter to Issuers, a good faith contract should offer terms comparable to terms that it offers to a similarly-situated non-ECP provider, except for terms that would not be applicable to an ECP, such as by virtue of the types of services that an ECP provides. Collecting this information will assist CMS in better determining issuer compliance with the ECP requirements pertaining to the offering of contracts in good faith to qualified ECPs.

## PROVIDER SITE INFORMATION

- *"Provider Site Name."* [Required field.] Enter the Provider Site Name at which you provide health care services to patients.
- *"Organization Name."* [Required field.] Enter the Organization Name that the insurance

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companies (i.e., issuers) would contact for purposes of contract negotiations.

- *“National Provider Identifier.”* [Required field.] Enter NPI in a 10-digit format (no hyphens). Affiliated practitioners who practice within a multi-practitioner facility should not submit a petition under their individual practitioner NPI; rather, only individuals authorized by the facility should submit the petition using the facility-level NPI, site name, and indicate the number of FTE practitioners practicing within the facility. In contrast, solo practitioners may submit the petition under their individual practitioner NPI.
- *“ECP Categories and Provider Types (Select all that apply).”* [Required field.] Select all categories that describe the health care services that you provide. For example, if the contracted provider is a Federally Qualified Health Center (FQHC) that is also a Ryan White HIV/AIDS provider, select both the FQHC and Ryan White Provider categories. However, if you are a dental provider and provide no non-dental medical services at your facility, please select only the “Dental Providers” ECP category or the FQHC – Dental Services ECP category (i.e., all of the non-dental ECP categories require the petitioner to enter the FTE counts for medical practitioners at the respective facility and the MD, DO, NP, and PA counts would not be applicable to a dental provider). If HHS is unable to verify your provision of these services with our Federal partners, we may default your listing to the “Other ECP Providers” category upon 340B verification.

#### ECP Categories and Provider Types (Select All that Apply)

- ☐ Family Planning Providers
- ☐ Federally Qualified Health Centers
  - ☐ FQHC – Medical Services
  - ☐ FQHC – Dental Services
- ☐ Inpatient Hospitals [Please indicate number of staffed hospital beds within the petition above and do not select any additional ECP categories other than Indian/Tribal indicators. For reporting additional ECP categories other than Indian/Tribal indicators, please complete a separate petition.]
  - ☐ Children’s Hospitals
  - ☐ Critical Access Hospitals
  - ☐ Disproportionate Share Hospitals (DSH) and DSH-eligible Hospitals
  - ☐ Freestanding Cancer Centers
  - ☐ Rural Referral Centers
  - ☐ Sole Community Hospitals
- ☐ Indian Health Care Providers

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- ☐ Programs operated by the Indian Health Service
  - ☐ Programs operated by a Tribe or Tribal organization under the authority of the Indian Self-Determination and Education Assistance Act
  - ☐ Programs operated by an urban Indian organization under the authority of Title V of the Indian Health Care Improvement Act
  - ☐ Ryan White Program Providers
  - ☐ Other ECP Providers
    - ☐ Black Lung Clinics
    - ☐ Community Mental Health Centers
    - ☐ Dental Providers
    - ☐ Hemophilia Treatment Centers
    - ☐ Rural Health Clinics
    - ☐ Sexually Transmitted Disease Clinics
    - ☐ Substance Use Disorder Treatment Providers (as recognized by the Substance Abuse and Mental Health Services Administration at <https://www.samhsa.gov/find-treatment>)
    - ☐ Tuberculosis Clinics
    - ☐ Other entities that are eligible for or participating in the 340B program (as determined by the Health Resources and Services Administration at <http://www.hrsa.gov/opa/eligibilityandregistration/index.html>) and serve predominantly low-income, medically underserved individuals
- “Which of these services, if any, do you provide to patients with opioid use disorder? (Select all that apply.)” [Required field.]
    - Screening ☐
    - List of addiction resources ☐
    - Coordination of care referral to addiction specialists ☐
    - Psychosocial/behavioral therapies ☐
    - Pharmacotherapy with methadone ☐
    - Pharmacotherapy with buprenorphine ☐
    - Pharmacotherapy with naltrexone ☐
    - Other ☐ You may specify here: \_\_\_\_\_
    - None ☐

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- *“Please respond to the following telehealth questions:”* [Required field.]
  - *“Which among the following telehealth services, if any, do you currently utilize in your medical practice? (Select all that apply.)”*
    - Sending telephone/text reminders to patients of upcoming appointments. ☐
    - Faxing or telephoning prescription orders to the patient’s pharmacy. ☐
    - Using computer/online technology to communicate test and/or lab results to patients. ☐
    - Using computer/online technology to allow two-way communication between patient and provider (e.g., patients can schedule appointments online and email questions to provider, etc.). ☐
    - Using a secure online video and audio conferencing software platform (e.g., Zoom) to provide patient care. ☐
    - Maintaining an updated and interactive website for your medical practice that serves to educate patients regarding best practices for maintaining wellness and recovering from illness. ☐
    - Other (please describe) \_\_\_\_\_(200 characters) ☐
    - None ☐
  - *“Which among the following services, if any, do you provide to your patients through telehealth options? (Select all that apply.)”*
    - Online patient portal ☐
    - Reporting of test and/or lab results to patients ☐
    - Patient access to their medical records ☐
    - Patient education promoting preventive health ☐
    - Medical appointment scheduling ☐
    - Patient triage services ☐
    - Diagnostic services ☐
    - Monitoring of patient health status ☐
    - Treatment of acute health conditions ☐
    - Treatment of chronic health conditions ☐
    - E-prescribing ☐
    - Other (please describe) \_\_\_\_\_(200 characters) ☐
    - None ☐
  - *“How often do you utilize telehealth services in your medical practice? (Select only one option.)”*
    - Daily ☐
    - Weekly ☐

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- Monthly ☐
  - None ☐
  - Other (please elaborate) \_\_\_\_\_(200 characters) ☐
- “Do you have plans to adopt or expand utilization of telehealth services in your medical practice in the near future? (Select only one option.)”
  - Yes (please elaborate) \_\_\_\_\_(200 characters) ☐
  - No ☐
  - Maybe/Unsure (please elaborate) \_\_\_\_\_(200 characters) ☐
- “Which among the following challenges, if any, have you faced with adopting or expanding telehealth services in your medical practice? (Select all that apply.)”
  - Cost (please elaborate) \_\_\_\_\_(200 characters) ☐
  - Patient access, interest, or understanding (please elaborate) \_\_\_\_\_(200 characters) ☐
  - Staff training (please elaborate) \_\_\_\_\_(200 characters) ☐
  - Credentialing of such services (please elaborate) \_\_\_\_\_(200 characters) ☐
  - State requirements/regulations (please elaborate) \_\_\_\_\_(200 characters) ☐
  - Marketplace insurance coverage or billing challenges (please elaborate) \_\_\_\_\_(200 characters) ☐
  - Other (please elaborate) \_\_\_\_\_(200 characters) ☐
  - None ☐
- “Describe any credentialing or other requirements set forth by your state and/or Marketplace insurance organizations operating in your state related to utilization of telehealth services? (Select all that apply.)”
  - State requirements (please elaborate) \_\_\_\_\_(200 characters) ☐
  - Marketplace insurance organization requirements (please elaborate) \_\_\_\_\_(200 characters) ☐
  - Other (please elaborate) \_\_\_\_\_(200 characters) ☐
  - None ☐
- “Which among the following added values, if any, have you experienced by adopting or expanding the use of telehealth services in your medical practice? (Select all that apply.)”
  - Patient convenience ☐
  - Staff convenience ☐
  - Cost effectiveness ☐
  - Increased patient quality of care ☐
  - Increased patient health outcomes ☐

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- Other (please describe) \_\_\_\_\_ (200 characters) ☐
- None ☐
- Not applicable because I do not utilize telehealth services in my medical practice ☐

- **“Site Street Address 1.”** [Required field.] Enter the street address at which you provide health care services to patients. If an individual provider practices in the same group or company at the same street location with other affiliated providers, the facility should submit only one petition, indicating the number of qualified FTE practitioners available at the facility within the petition above.
- **“Site Street Address 2.”** Enter the suite number, floor number, or other secondary address information (associated with the same street location in Site Street Address Line 1) at which you provide health care services to patients. [Please do not enter a separate street location in this field if your facility offers multiple locations; instead, submit a separate petition for any additional practice sites.] If an individual provider practices in the same group or company at the same street location with other affiliated providers, the facility should submit only one petition, indicating the number of qualified FTE practitioners available at the facility within the petition above.
- **“Site City.”** [Required field.] Enter the Site City in which you provide health care services to patients.
- **“Site State.”** [Required field.] Enter the Site State in which you provide health care services to patients.
- **“Site ZIP Code.”** [Required field.]  
Enter the Site ZIP code in which you provide health care services to patients. Your ZIP code must be located within a low-income ZIP code or Health Professional Shortage Area (HPSA), based on the HHS “Low-Income and HPSA ZIP Code Listings” available at <https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>. You are exempt from this requirement if you are one of the following types of providers: (1) eligible for or participating in the 340B program; (2) a Rural Health Clinic; (3) an Indian health care provider; or (4) a State-owned family planning service site, governmental family planning service site, or not-for-profit family planning service site that does not receive Federal funding under special programs, including under Title X of the PHS Act or other 340B-qualifying funding.

## ORGANIZATION INFORMATION

- **“Site County.”** [Required field.] Enter the Site County in which you provide health care services to patients. Site county information is used for purposes of insurance companies (i.e., issuers) meeting the requirement in the Federally-facilitated Marketplace to offer a

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contract in good faith to at least one ECP in each ECP category in each county in the service area.

- *“Org Street Address 1.”* [Required field.] Enter the Organization Street Address that the issuer would use to contact you for purposes of contract negotiations.
- *“Org Street Address 2.”* Enter the secondary Organization Street Address that the insurance companies (i.e., issuers) would use to contact you for purposes of contract negotiations.
- *“Org City.”* [Required field.] Enter the Organization City that the insurance companies (i.e., issuers) would use to contact you for purposes of contract negotiations.
- *“Org State.”* [Required field.] Enter the Organization State that the insurance companies (i.e., issuers) would use to contact you for purposes of contract negotiations.
- *“Org ZIP Code.”* [Required field.] Enter the Organization ZIP code that the insurance companies (i.e., issuers) would use to contact you for purposes of contract negotiations.
- *“Org County.”* [Required field.] Enter the Organization County that the insurance companies (i.e., issuers) would use to contact you for purposes of contract negotiations. Organization county information is not used for purposes of issuers meeting the requirement in the Federally-facilitated Exchange to offer a contract in good faith to at least one ECP in each ECP category in each county in the service area. Instead, the Site County field above is used for purposes of that ECP requirement.

#### POINT OF CONTACT (POC) INFORMATION

- *“POC 1 Name.”* [Required field.] Enter the Primary Point of Contact Name that the insurance companies (i.e., issuers) would use to contact you for purposes of contract negotiations. This field entry must not be identical to the POC 2 Name field entry within the petition below.
- *“POC 1 Title.”* [Required field.] Enter the Primary Point of Contact Title that the insurance companies (i.e., issuers) would use to contact you for purposes of contract negotiations.
- *“POC 1 Phone.”* [Required field.] Enter the Primary Point of Contact Phone # that the insurance companies (i.e., issuers) would use to contact you for purposes of contract negotiations.
- *“POC 1 Phone Ext.”* Enter the Primary Point of Contact Phone Ext that the insurance companies (i.e., issuers) would use to contact you for purposes of contract negotiations.
- *“POC 1 Email.”* [Required field.] Enter the Primary Point of Contact Email that the insurance companies (i.e., issuers) would use to contact you for purposes of contract negotiations. This field entry must not be identical to the POC 2 Email field entry within the petition below.
- *“POC 2 Name.”* Enter the Alternate Point of Contact Name that the insurance companies (i.e., issuers) would use to contact you for purposes of contract negotiations. This field entry

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must not be identical to the POC 1 Name field entry within the petition above.

- *“POC 2 Title.”* Enter the Alternate Point of Contact Title that the insurance companies (i.e., issuers) would use to contact you for purposes of contract negotiations.
- *“POC 2 Phone.”* Enter the Alternate Point of Contact Phone # that the insurance companies (i.e., issuers) would use to contact you for purposes of contract negotiations.
- *“POC 2 Phone Ext.”* Enter the Alternate Point of Contact Phone Extension that the insurance companies (i.e., issuers) would use to contact you for purposes of contract negotiations.
- *“POC 2 Email.”* Enter the Alternate Point of Contact Email that the insurance companies (i.e., issuers) would use to contact you for purposes of contract negotiations. This field entry must not be identical to the POC 1 Email field entry within the petition above.
- *“Provider Website.”* Enter the provider website that the insurance companies (i.e., issuers) can visit to learn more about the services you offer at your facility.

## VALIDATING AND SUBMITTING PROVIDER PETITION

1. Click the window within the “I’m not a robot” reCAPTCHA box to verify that you are not an automated computer program.
2. Click the **“Preview your Petition before Submitting”** button at the bottom of petition.
3. If the petition has any errors, an error window will appear and indicate the data fields containing each error. **Correct** any identified errors and click **“Preview your Petition before Submitting.”**
4. If you need assistance with correcting any errors, click the **“Need Help”** button to view the email address to submit your question(s) to the ECP communications mailbox: [EssentialCommunityProviders@cms.hhs.gov](mailto:EssentialCommunityProviders@cms.hhs.gov).
5. If the petition has no errors (or once all errors have been resolved), the preview screen will appear and display all data entries. Confirm the accuracy of the data entries and then click the final **“Submit Petition”** button to submit your petition. A confirmation screen will appear once your petition has been submitted successfully.

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