Market Reform and Policy Issues for Implementation of Health Reform in North Carolina

Work Group Meeting – Essential Community Providers

August 30, 2012

MANATT HEALTH SOLUTIONS

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Agenda

2:00 – 2:15	**Welcome and Introductions**
2:15 – 2:45	Goals/Objectives of Work Group and Today's Discussion
2:45 – 3:05	Update on "Essential Community Providers" under Final Federal Exchange Rules & Current State Statute
3:05 – 4:00	Items for Discussion in ECP Work Group: • Who are Essential Community Providers in North Carolina? Are there providers, while not specified in federal statute, who should fall within the definition of ECPs in North Carolina?
4:00 – 4:15	*Break*
4:15 – 4:45	Items for Discussion in ECP Work Group, continued: • How should North Carolina define a "sufficient number and geographic distribution" of ECPs to ensure "reasonable and timely access" for "low income, medically underserved individuals"? How would such a standard be measured?
4:45 – 5:00	Wrap Up and Next Steps

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  - Healthcare Financing & Reimbursement
  - Strategic Partnerships
  - International Health Policy

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Overall Project Goal and ECP Work Group Meeting Objectives

Project Purpose: *Develop policy options and considerations and identify areas of consensus to inform the NC DOI actions and recommendations for Exchange-related market reform policies.*

(pursuant to North Carolina Session Law 2011-391)

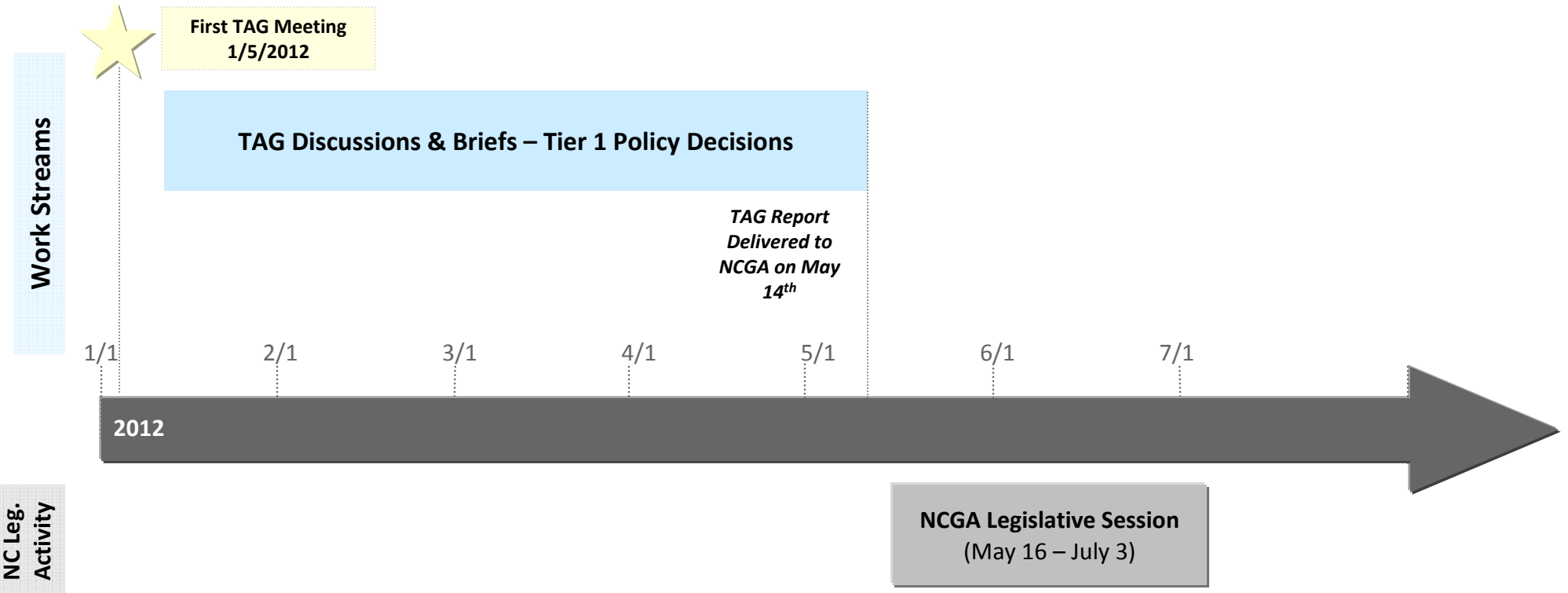
"It is the intent of the General Assembly to establish and operate a State-based health benefits Exchange that meets the requirements of the [ACA]...The DOI and DHHS may collaborate and plan in furtherance of the requirements of the ACA...The Commissioner of Insurance may also study insurance-related provisions of the ACA and any other matters it deems necessary to successful compliance with the provisions of the ACA and related regulations. The Commissioner shall submit a report to the...General Assembly containing recommendations resulting from the study."

-- Session Law 2011-391

Objectives for Today's Meeting

- Explain the Role and Expectations of the Work Group in Relation to the Overall Project and Role of the Technical Advisory Group (TAG)
- Provide Background on Essential Community Providers (ECP) and Network Adequacy Standards
- Identify ECP Options to Set Before the TAG for Consideration

Past Project and Regulatory Timeline



Federal Guidance and Activity

Planning — Development of a Federal Exchange — *Testing*

Recent Relevant Guidance Already Issued

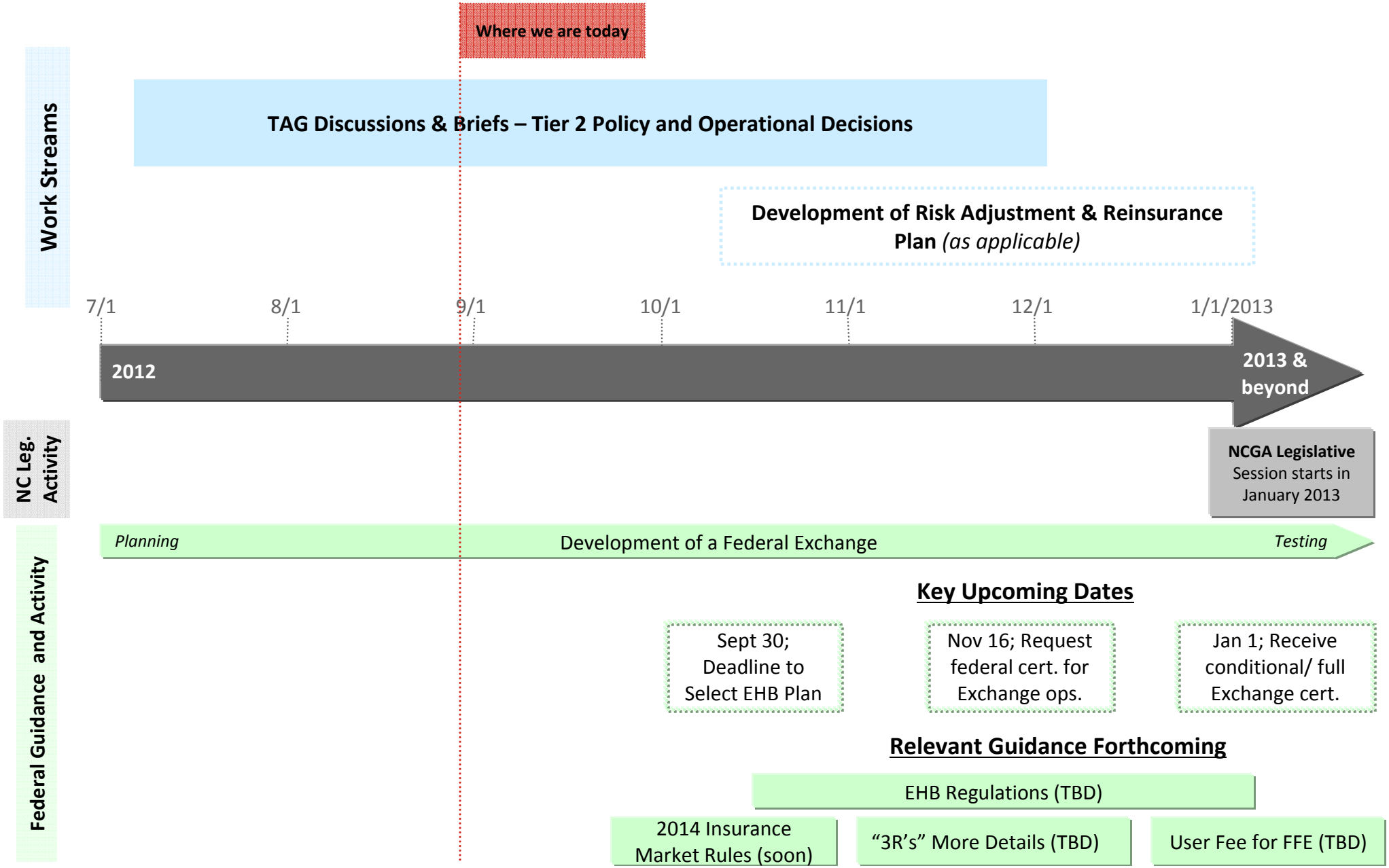
EHB Bulletin (Dec. 2011)

- **Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers Final and Interim Final Rules (March 2012)**
- **"3R's" Reinsurance, Risk Corridors & Risk Adjustment Final Rule (March 2012)**
- **Medicaid Eligibility Changes under the ACA Final Rule (March 2012)**
- **Health Insurance Premium Tax Credit Final Rule (March 2012)**

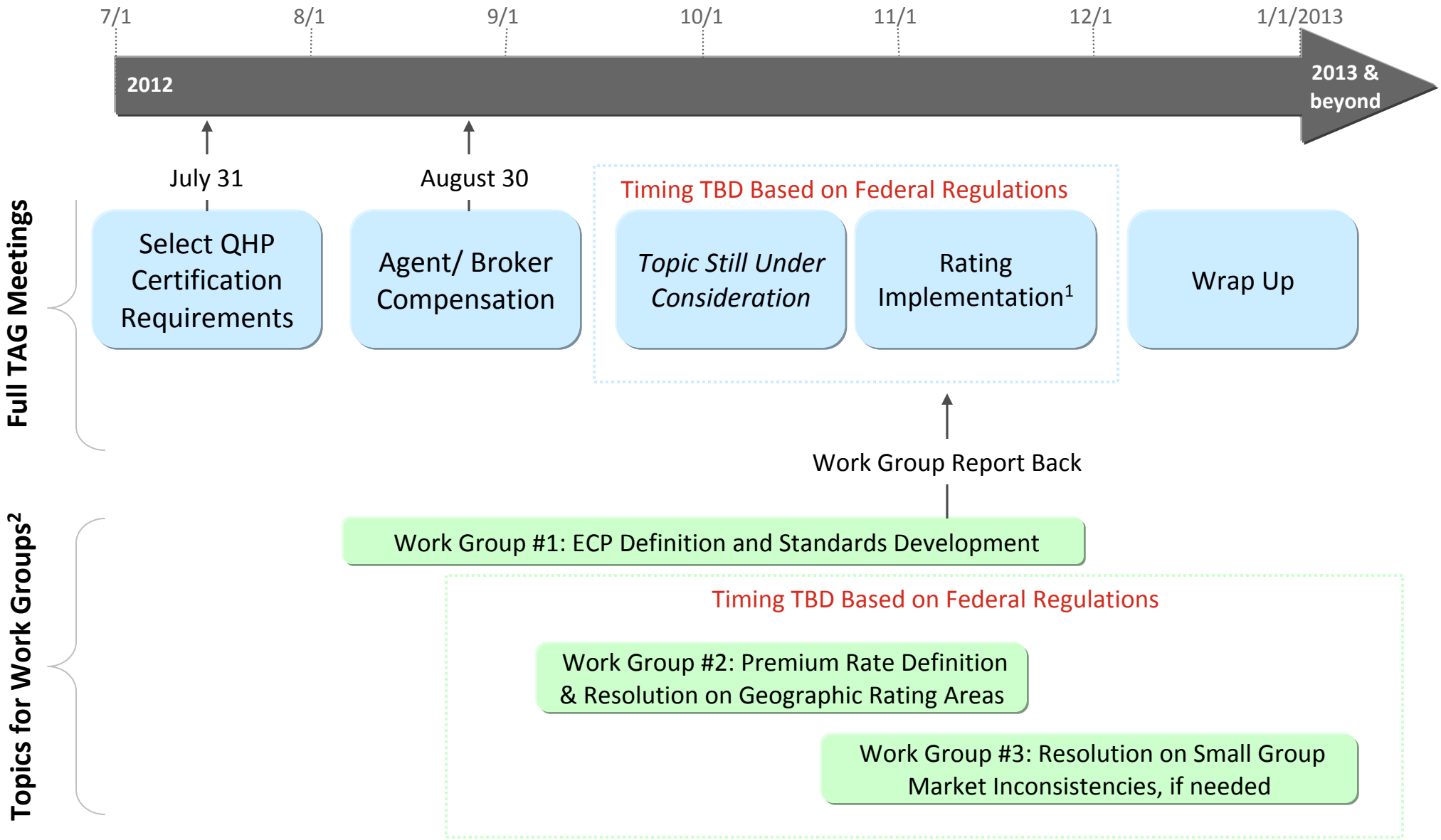
Draft Blueprint for SBEs and Partnerships; Guidance on FFEs (May 2012)

EHB Data Collection Standards and QHP Accreditation Final Rule (July 2012)

Current Project and Regulatory Timeline



Tentative TAG Meeting and Work Groups Planning



[1]Webinar will lively precede Work Group #2 meeting and Rating Implementation TAG meeting once regulations are released

[2]Work Groups will be held as needed to address technical issues and to arrive at options to set before the TAG.

ECP Work Group Goal for North Carolina

The goal of the ECP Work Group is to set forth options and approaches to meeting ECP requirements for broader TAG consideration.

Baseline — ***Continuum of Options for ECP Measurement*** — More

Adjustment to Current State Process

Options between "Adjustment to Current State Process" and "Establish Comprehensive New Measures" fall along different points in the continuum

Establish Comprehensive New ECP Measures

- *Options development should take into account the potential for the TAG to reach consensus and make a recommendation to the NC DOI on an ECP standard*
- *Options can also take into account a gradual process, if needed (e.g., Year One options versus options to be considered in later years)*

Role and Expectations of the ECP Work Group

- The purpose of the work group is to provide technical expertise and stakeholder input to support broader TAG discussion.
  - Participants invited because of expertise and experience in the topic under discussion
  - Anticipated that group will meet twice to work through issues prior to TAG discussion
- The work group will identify policy options and considerations for the TAG; the TAG, in turn, will recommend preferred options to the NC DOI, who will develop recommendations, as applicable, to the NCGA
  - Focus is on OPTIONS DEVELOPMENT
  - Identification of pros/cons of certain options will be noted and shared with TAG as needed
- Understand that there is uncertainty on the type of Exchange model the state will implement
  - Under the full FFE model the state may not be able to set ECP standards for the Exchange

Role and Expectations of Work Group Participants

- Work Group members will:
  - Be a consistent presence
  - Meet timelines
  - Contribute expertise
  - Consider perspectives from diverse stakeholder groups
  - Be solution-oriented
  - Respect the opinions and input of others
  - Work toward options development

Statement of Values to Guide TAG Deliberations

The TAG will seek to evaluate the market reform policy options under consideration by assessing the extent to which they:

- Expand coverage;
- Improve affordability of coverage;
- Provide high-value coverage options in the HBE;
- Empower consumers to make informed choices;
- Support predictability for market stakeholders, competition among plans and long-term sustainability of the HBE;
- Support innovations in benefit design, payment, and care delivery that can control costs and improve the quality of care; and
- Facilitate improved health outcomes for North Carolinians.

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Relevant Federal Laws and Regulations - Network Adequacy

Final rules set out specified network adequacy criteria that an insurer must satisfy in order for each plan to qualify as a QHP.

- Insurers must ensure that the provider network for each QHP:
  - Includes essential community providers (ECPs) (*45 CFR §156.230(a)*)
  - Maintains a network that "is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay." (*45 CFR §156.230(a)*) [1]
  - Is consistent with network adequacy provisions in Section 2702(c) of the PHS Act. (*45 CFR §156.230(a)*)
  - A QHP Insurer must also make its provider directory available to the Exchange. (*45 CFR §156.230(b)*)
    - The directory must identify which providers are not accepting new patients

Relevant Federal Laws and Regulations – ECPs

The threshold for ECPs is separate, and more stringent, than the general provider network requirements.

- QHPs must have a "**sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access for low- income, medically underserved individuals**." *(45 CFR §156.235(a)(1))*
- ECPs are defined as providers that serve predominately low-income, medically underserved individuals. *(45 CFR §156.235(c)(1))*
  - ECPs must include providers meeting the criteria defined in section 340B(a)(4) of the PHS act or section 1927(c)(1)(D)(i)(IV) of the Act
- QHPs are not obligated to provide coverage for any specific medical procedure provided by an ECP. *(45 CFR §156.235(a)(3))*
- QHP insurers are not required to contract with ECPs that refuse to accept "generally applicable payment rates." *(45 CFR §156.235(d))*
- A QHP insurer must pay a FQHC no less than the relevant Medicaid prospective payment system (PPS) rate, or, alternatively, may pay a mutually agreed upon rate to the FQHC provided that such rate is at least equal to the QHP issuer's generally applicable rate. *(45 CFR §156.235(e))*

NAIC Model Act – Network Adequacy Standard

"A health carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week. Sufficiency shall be determined in accordance with the requirements of this section, and may be established by reference to any reasonable criteria used by the carrier, including but not limited to: provider-covered person ratios by specialty; primary care provider covered person ratios; geographic accessibility; waiting times for appointments with participating providers; hours of operation; and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care."

-- *NAIC Managed Care Plan Network Adequacy Model Act*[1]

1) The NAIC Network Adequacy White Paper mentions that the NAIC Model Act may need to be updated to ensure compliance with ACA standards by adding in mental health providers. However, the paper also states that "while the Affordable Care Act and the final rules prescribe that mental health providers be incorporated into networks for plans inside the Exchange, it must be recognized that mental health is covered under many circumstances outside the Exchange such as federal mental health parity, State specific mental health mandates and plans that choose to cover mental health. Therefore, mental health providers should be a component of networks inside and outside the Exchange."

Relevant NC Laws and Regulations

North Carolina Existing Statute & Administrative Code

- NC Statute defines health insurers[1] and those insurers are subject to the administrative code, as follows:

- **Provider Availability Standards.** Each network plan carrier shall develop a methodology to determine the size and adequacy of the provider network necessary to serve the members. The methodology shall provide for the development of performance targets that shall address the following:
    1. The number and type of PCPs, specialty care providers, hospitals, and other provider facilities, as defined by the carrier;
    2. A method to determine when the addition of providers to the network will be necessary based on increases in the membership of the network plan carrier;
    3. A method for arranging or providing health care services outside of the service area when providers are not available in the area. (*NC Administrative Code 11 NCAC 20 .0301*)

[1] § 58-1-5(3) “"Company" or "insurance company" or "insurer" includes any corporation, association, partnership, society, order, individual or aggregation of individuals engaging or proposing or attempting to engage as principals in any kind of insurance business.....”’ § 58-65-1 (a) defines hospital, medical and dental services plans. NC also has HMO adequacy standards for initial reviews of HMO plans.

Relevant NC Laws and Regulations (cont.)

North Carolina Existing Statute & Administrative Code (cont.)

- **Provider Accessibility Standards.** Each carrier shall establish performance targets for member accessibility to primary and specialty care physician services and hospital based services. Carriers shall also establish similar performance targets for health care services provided by providers who are not physicians. Written policies and performance targets shall address the following:
    1. Proximity of network providers as measured by such means as driving distance or time a member must travel to obtain primary care, specialty care and hospital services, taking into account local variations in the supply of providers and geographic considerations;
    2. The availability to provide emergency services on a 24-hour, seven day per week basis;
    3. Emergency provisions within and outside of the service area;
    4. The average or expected waiting time for urgent, routine, and specialist appointments. (*NC Administrative Code 11 NCAC 20 .0302)*

Relevant NC Laws and Regulations (cont.)

North Carolina Existing Statute & Administrative Code (cont.)

- **Services Outside Provider Networks.** No insurer shall penalize an insured or subject an insured to the out-of-network benefit levels offered under the insured's approved health benefit plan, including an insured receiving an extended or standing referral under NCGS 58-3-223, unless contracting health care providers able to meet health needs of the insured are reasonably available to the insured without unreasonable delay. (*NCGS 58-3-200(d)*)

- North Carolina's statutes generally follows the NAIC Model Act.
- North Carolina offers consumer protections if in-network providers are not available.
- North Carolina's statute is likely sufficient for meeting ACA network adequacy requirements for QHPs, with the exception of Essential Community Providers.

In addition, NCGS § 58-3-190 requires insurers to provide coverage for emergency services, without prior authorization, if a prudent layperson acting reasonably would have believed that an emergency medical condition existed.

What other states are doing re: ECPs

State	Approach to Essential Community Providers
Hawaii	Legislation dictates that "the director of health, with the concurrence of the director of human services, shall have the authority to designate other Hawaii health centers not yet federally designated but deserving of support to meet short term public health needs based on the department of health's criteria, as Hawaii Qualified Health Centers." (L 1994, c 238, §2)
Washington	Requires QHPs to include tribal clinics and urban Indian clinics as ECPs. Also allows integrated delivery systems to be exempt from the requirement to include ECPs, if permitted. *(HB 2319)*
Vermont	Intends to emphasize the importance of family planning clinics as ECPs and encourages federal lawmakers to follow by including all family planning clinics as opposed to a "sufficient number."[1]
California	Exchange Board is reviewing options and recommendations for QHPs. Preliminary recommendations include: expanding the definition of ECPs to include private practice physicians, clinics and hospitals that serve Medi-Cal and low-income populations; establish criteria to identify providers that meet the definition of ECPs; and require plans to demonstrate sufficient participation of ECPs by showing the overlap between ECPs an the regions low-income population.
Minnesota	Current law is "stronger than federal requirements and requires health plans that contract with providers to offer contracts to all state-designated essential community providers in its service area." *(§62Q.19)*

1. Vermont comment on the proposed HHS Exchange Establishment Standards (Part 155) and (Part 156)
2. http://www.healthexchange.ca.gov/StakeHolders/Documents/CA%20HBEX%20-%20QHP%20Options%20Webinar.pdf

What Stakeholders Recommend re: ECPs

Excerpt from National Dialogue

- The **National Association of Community Health Centers** maintains that "health centers are **crucial network participants for QHPs** because they provide cost-effective and cost-efficient primary and preventive health care and enabling services to a predominantly low-income population, and **they embody principles of patient-centered primary care that Congress sought to propagate through various provisions of the ACA**... Practically, in order to build comprehensive networks, QHPs must include FQHCs. Congress recognized this reality in Section 1311(c) of the ACA, which refers to 'essential community providers' including health centers."[1]
- **NAIC**: "... it would make sense for the State to extend [its own adequacy] requirements to QHPs to minimize adverse selection against the Exchange. However, **in some cases, the ACA's network adequacy standards may go beyond a State's existing requirements, particularly as related to its requirement that essential community providers be included in the QHP's provider network**. ....each State will need to consider whether to apply the same standards for QHP certification to the outside market, the potential for adverse selection against the Exchange if they choose not to require the same standards and the cost to issuers in the outside market to comply if they choose to require the same standards."[2]
- **National Association of School Based Health Clinics** (NASBHC) submitted comments to HHS that advocated for the **inclusion of school-based health centers** in the list of essential community providers noting that "SBHCs expand access to care for vulnerable populations of children and adolescents and function as safety-net providers. We respectfully request that ECP regulations reflect this position by including SBHCs as essential community providers."[3]
- The **American Nurses Association** urges states to **allow nurse-managed clinics to qualify as essential community providers** in an effort to "protect consumers; improve the quality of care; emphasize primary care, care coordination, disease management, and prevention; increase community-based care; and utilize nurses to their fullest capabilities, as leaders and essential members of inter-professional health care teams."[4]

1. NACHC Comments on Essential Health Benefits Bulletin (Dec. 16, 2011)
2. NAIC Plan Management Function: Network Adequacy White Paper (June 27, 2012)
3. NASBHC comments to DHHS regarding school-based health centers (September 28, 2011
4. "The American Nurse." *Affordable Care Act is still the law. (*August 6, 2012)

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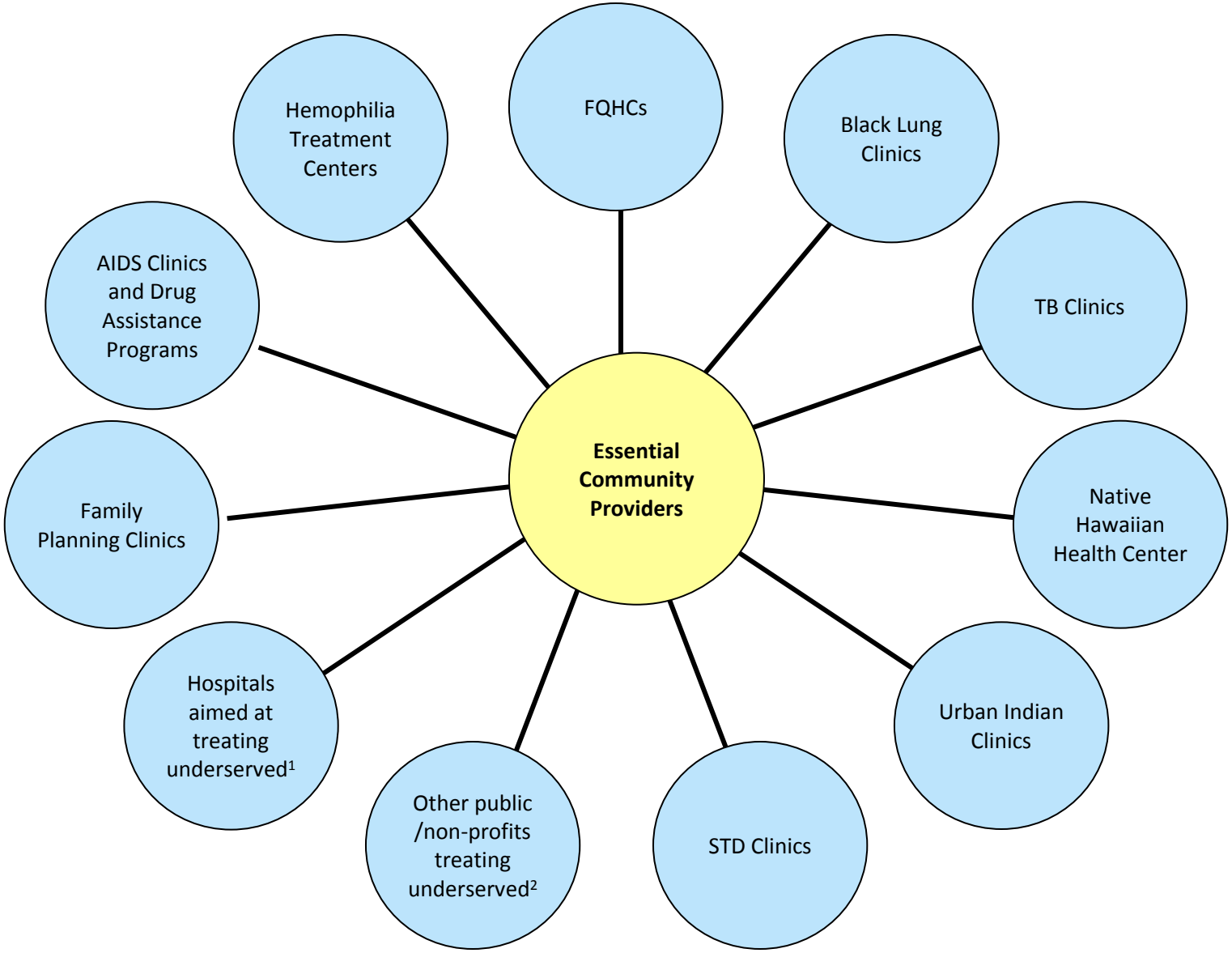
Essential Community Providers in Federal Regulations



1. Includes disproportionate share hospitals, critical access hospitals, children's hospital excluded from the Medicare PPS, free-standing cancer hospital excluded from PPS, and sole community hospitals.
2.Defined in 1927(c)(1)(D)(i)(IV) of the Social Security Act
Source: PHSA section 340B(a)(4)

ECPs in North Carolina – As Defined by Statute

Provider Type	Description	Number of Providers
FQHC	• Located in a medically underserved area (MUA) or serve a medically underserved population • Provide comprehensive primary and preventive health care services regardless of a person's ability to pay • Community based board of directors	• 34 at nearly 160 different sites

Local Health Departments	• Required by state law to provide certain services including. communicable disease control, environmental health services, and vital records registration
	• Provide child and adult immunizations, STD and HIV/AIDS testing and counseling, TB testing, family planning, and case management
	• Many provide child health clinics, prenatal care, and nutrition services
	• North Carolina health departments are more likely to provide clinical services than health departments in other states
		• 85 local public health departments in North Carolina
		  • 79 single-county
		  • 6 multi-county

Planned Parenthood	• All provide family planning, women's health services, men's health care services, HIV testing, STD testing and treatment, and pregnancy testing and services • Some provide general health care services and abortion services	• 9 locations

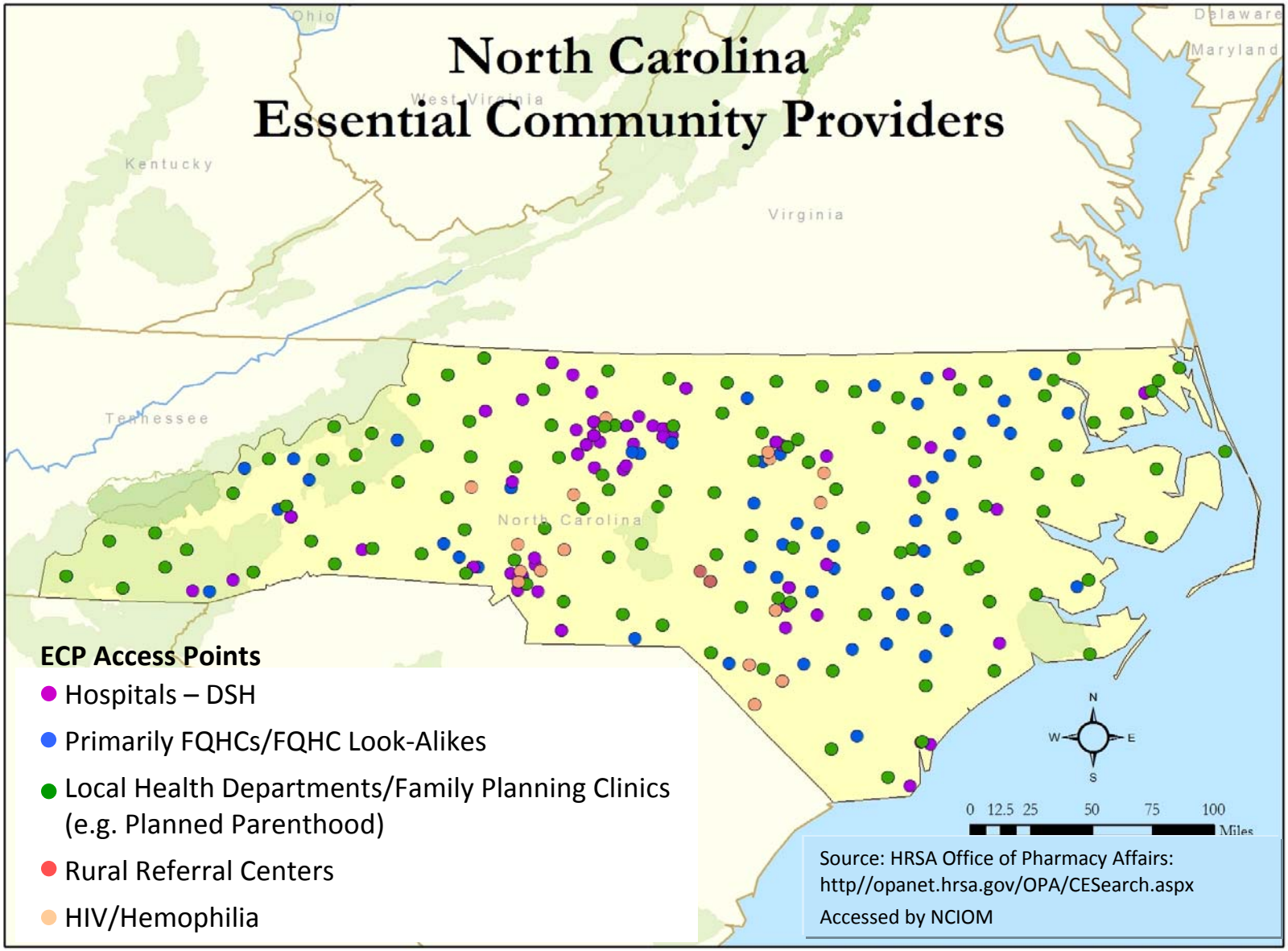
ECPs in North Carolina – As Defined by Statute (Continued)

Provider Type	Description	Number of Providers
Ryan White Clinics and AIDS Drug Assistance Program	• Part A: Provide HIV-related services for individuals with limited health care coverage or financial resources • Part B: Offer emergency assistance to Eligible Metropolitan Areas and Transitional Grant Areas that are most severely affected by the HIV/AIDS as well as drug assistance program • Part C: Supply comprehensive outpatient primary care • Part D: Provide family-centered care including outpatient or ambulatory care for women, infants, and youth with HIV/AIDS	• Part A: 1 program • Part B: 6 programs • Part C: 12 programs • Part D: 7 programs
Hemophilia Clinic	• Offer diagnostic and treatment services for people with hemophilia • Centers typically include a broad range of health professionals, including hematologists, pediatricians, nurses, social workers, physical therapists, orthopedists, and dentists.	• 2 locations

Other Potential ECP Entities

Provider Type	Description	Number of Providers
Rural Health Centers	• Located in areas with limited primary care resources • Provide primary care and routine diagnostic and therapeutic care • Some provide dental and behavioral health services	• 86 federally certified centers • 19 state-funded centers
School Based/Linked Health Centers	• Provide primary care, mental health, acute and chronic disease management, immunizations, medical exams, sports physicals, nutritional counseling, health education, prescriptions, and medication administration	• 55 centers
Other Non-Profits Aiming to Treat Uninsured	• Example: North Carolina Community Care Network which is aimed at managing care for the Medicaid population	• 14 Community Care Networks

Geographic Distribution of ECPs in North Carolina



Based on entities receiving 340(b) pricing, some entities not included

Options Development- Identifying ECPs in North Carolina

1. *Are there other provider types that North Carolina should consider for inclusion as an Essential Community Provider?*
2. *Are there providers, while not specified in federal statute, that should fall within the definition of ECPs in North Carolina?*

   (e.g., Rural Health Centers, School-based Clinics, Community Care of NC, etc.)
3. *Are there any other options around identification of ECPs in North Carolina that the work group should consider?*

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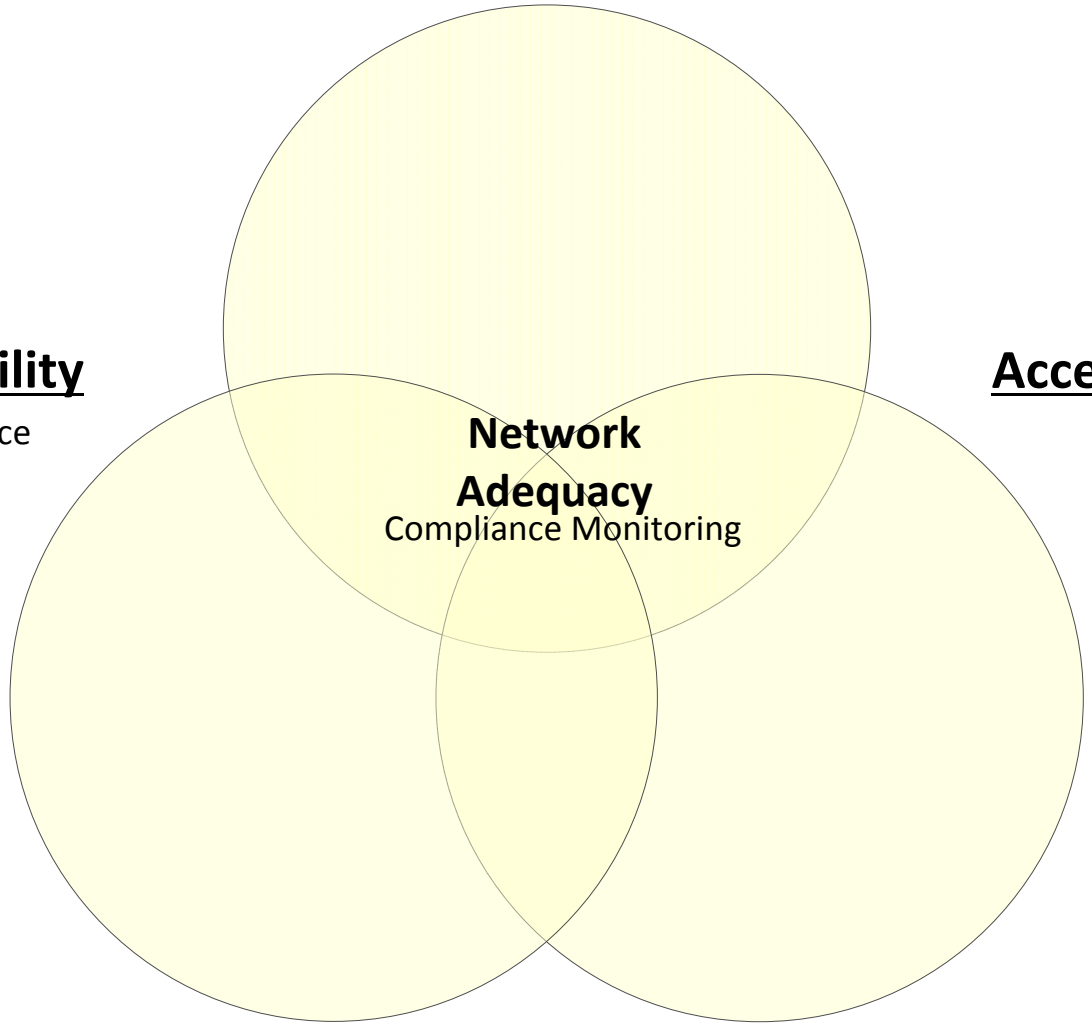
Variety of Metrics Used to Measure Network Adequacy

Distribution and Number of Providers

Such as: Provider to Enrollee Ratios
Provider Mix
Number and Type of Covered Lives



Geographic Variability

Such as: Travel Time/Distance
Geographic Designation

Accessibility to Providers

Such as:
Appointment Wait Time
Appointment Availability
Standards

Common Measures Used to Assess Network Adequacy

Common Measures Used In the Industry

Measures	Rationale and Sample Metrics
Provider Type	Ensures that networks are broad to meet potential range of enrollee needs (E.g. PCP vs. emergency care vs. family planning)
Provider Ratios	Assesses the number of enrollees served by a provider type (E.g. 2 providers: 1,500 enrollees)
Number and Type of Covered Lives	Encourages adequate number and mix of providers accessible to targeted population (E.g. 5,000 enrollees, 100 of which have diabetes)
Appointment Availability Standards	Standards for appointment availability take into account the urgency of the need for services (E.g. Within 4 weeks of request)
Appointment Waiting Time Standards	Includes requirements for in-office waiting times to ensure beneficiary has timely access to care (E.g. No longer than 1 hour)
Travel Time/Distance standards	Limits distance enrollee must travel to receive care. This can vary based on whether enrollee resides in an urban or rural area or provider type. (E.g. 30 minutes/30 miles)
Geographic Designation	Ensures that geographic barriers and concentration of membership are taken into consideration (E.g. Urban vs. rural)

Note: Not all measures are used within a particular state or insurer

North Carolina Network Adequacy Reporting

Geographic Provider Accessibility Standards (HMO)

HMO	Area	PCP	Pediatric	OB/Gyn	Specialist	Non-MD	Acute Facility	Out patient Facility	Mental Health	Mental Health non-MD	Mental Health Facility
Plan 1	Rural	2:30 miles	2:30 miles	2:30 miles	2:25 miles	2:25 miles	1:20 miles	1:20 miles	1:15 miles	1:15 miles	1:20 miles
Plan 2	Urban	1:10 miles	1:10 miles	1:10 miles	1:10 miles	1:15 miles	1:10 miles	1:15 miles	1:15 miles	1:20 miles	1:25 miles
Plan 3	Suburban	1:20 miles	1:20 miles	1:15 miles	1:25 miles	1:30 miles	2:30 miles	2:30 miles	1:20 miles	1:20 miles	1:30 miles

- North Carolina HMOs/PPOs report across the same provider types
- North Carolina does not set enrollee to provider ratios, rather each HMO/PPO develops enrollee to provider standards *(e.g., 2 providers within 30 miles)*
- Most HMOs/PPOs also distinguish against geographic designation (rural/urban/suburban) but it is not required

Source: North Carolina Department of Insurance Annual Report and Analysis of 2010 Activity; Requirements apply to PPOs as well

Common State Medicaid Managed Care Network Adequacy Standards

	AZ	MN	NY	TN	WA	WI
Network Adequacy Measures						
Provider-to-enrollee ratios specified	--	--	✓	✓	--	✓
Detailed requirements for specialty networks	✓	--	✓	✓	--	--
Timely Access to Covered Services Measures						
Appointment availability standards	✓	✓	✓	✓	✓	✓
Appointment waiting time standards	✓	--	✓	✓	--	✓
Travel time/distance standards	✓	✓	✓	✓	✓	✓
Compliance monitoring specified	✓	--	✓	✓	--	✓

Source: Manatt Health Solutions and Center for Health Strategies," Medicaid Managed Care: How States' Experience Can Inform Exchange Qualified Health Plan Standards." November 2011

Example: State Medicaid Managed Care Network Adequacy Standards

Example of State Network Adequacy Standards for Physicians (Non-Urgent Care)

Measures	State	
	NY Metrics	TN Metrics
Provider-to-enrollee ratios specified	1,500 members :1 physician (PCP) 1,000 members:1 nurse practitioner	2,500 members:1physician (PCP) 1,250 members:1 physician extender Varies for specialists
Detailed requirements for specialty networks	Varies by specialist type	Varies by specialist type
Appointment availability standards	4 weeks (PCP) 4-6 weeks (specialist)	3 weeks (PCP) 30 days (specialist)
Appointment waiting time standards	1 hour	45 minutes
Travel time/distance standards	30 min/miles	30 min/miles (rural) 30 min/20 miles (urban)
Compliance monitoring specified	SDOH and DHHS can monitor quality, appropriateness, and timeliness	NCQA Standards and Guidelines for Accreditation of MCOs

Source: Manatt Health Solutions and Center for Health Strategies. "Medicaid Managed Care: How States' Experience Can Inform Exchange Qualified Health Plan Standards." November 2011

Medicare Advantage Network Adequacy Standards

Metric	Requirement
Provider-to-enrollee ratios specified	CMS publishes minimum provider per 1,000 beneficiary ratios based on county type designation (e.g Large Metro, Metro, Micro, Rural, and CEAC)
Requirements for specialty facilities and providers	Plans must contract with ”sufficient” numbers of provider and facility specialty type to meet the criteria for the minimum number of provider specialties based on county type designation and population”
Beneficiaries Required to Cover	Number of Medicare beneficiaries in a county is multiplied by the “applicable percentage” (based on county type designation) of beneficiaries served by MA organizations
Travel time/distance standards	90% of beneficiaries in a given county must have access to at least one provider for a given specialty within the time/distance requirement for that county

Source: CY2013 CMS MA Health Services Delivery Provider & Facility Specialties and Network Adequacy Criteria Guidance

Setting ECP Standards for North Carolina

Regulations require, but do not set standards for, a "sufficient number" and "geographic distribution" of ECP providers to "ensure reasonable and timely access" to "low income medically-underserved individuals."

Baseline — ***Continuum of Options for ECP Standard-Setting*** — More

Adjustment to Current State Standard:

- Apply "reasonably available ..without unreasonable delay" to ECPs specifically
- Allow plans to set their own standards

Considerations:

- Similar to current market practices
- May or may not be sufficient to meet needs of low-income, medically underserved consumers
- May be difficult to objectively measure across insurers for the purposes of Exchange Certification

Options between "Adjustment to Current State Standard" and "Establish Comprehensive New Standards " fall along different points in the continuum

Establish Comprehensive ECP Standards:

- Establish measures and metrics that set forth specific numbers, geographic time/distance metrics, and methodology for determining "low income and medically underserved" populations

Considerations:

- Shift in current market practice which could be difficult to implement
- May be easier to objectively measure for purpose of Exchange Certification
- Detailed standards may help ensure that low-income, medically underserved consumers measurably have access

Potential Options for Setting Standards for ECPs in North Carolina

1. *What are the different approaches that could be used in North Carolina to meet the federal requirements?*

   Regulations require, but do not set standards for, a "sufficient number" and "geographic distribution" of ECP providers to "ensure reasonable and timely access" to "low income medically-underserved individuals."

2. *To what extent should NC require the QHPs to set their own standards/specific measures?*

3. *To what extent should NC set the standards/specific measures that QHPs should meet?*

Sample Options for ECP Standards

Baseline — ***Continuum of Options for ECP Standard-Setting*** — More

Option 1:

Plan Establishes Measurements and Metrics for ECP

- Plans set their own standards for ECPs
- Report on those standards to the state

Option 2:

State Sets Specific Reporting Measures; Plans set Metrics

- State requires reporting by provider type (similar to current process)
- Plans set their own standards for ECPs

Option 3:

State Establishes Baseline Measures for All Plans to Follow

- State requires a specific group of measurements with some specific metrics (e.g. appointment travel times, appointment wait times, specific ratios, etc.) on which plans must report

Option 4:

Establish Comprehensive ECP Standards

- State establishes measures and metrics that set forth specific numbers of ECPs, geographic time/distance metrics, and methodology for determining "low income and medically underserved" populations

Agenda

2:00 – 2:15	**Welcome and Introductions**
2:15 – 2:45	Goals/Objectives of Work Group and Today's Discussion
2:45 – 3:05	Update on "Essential Community Providers" under Final Federal Exchange Rules & Current State Statute
3:05 – 4:00	Items for Discussion in ECP Work Group: • Who are Essential Community Providers in North Carolina? Are there providers, while not specified in federal statute, who should fall within the definition of ECPs in North Carolina?
4:00 – 4:15	*Break*
4:15 – 4:45	Items for Discussion in ECP Work Group, continued: • How should North Carolina define a "sufficient number and geographic distribution" of ECPs to ensure "reasonable and timely access" for "low income, medically underserved individuals"? How would such a standard be measured?
4:45 – 5:00	Wrap Up and Next Steps

Next Steps

- **Take feedback from meeting and develop preliminary options for TAG consideration**
- **Gather again to discuss options**

Questions?

ECP: Federal Definition *(45 CFR §156.235)*

"(a) *General requirement.* (1) A QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards. (2) A QHP issuer that provides a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group may instead comply with the alternate standard described in paragraph (b) of this section. (3) Nothing in this requirement shall be construed to require any QHP to provide coverage for any specific medical procedure provided by the essential community provider.

(b) *Alternate standard.* A QHP issuer described in paragraph (a)(2) of this section must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

(c) *Definition.* Essential community providers are providers that serve predominantly low-income, medically underserved individuals, including providers that meet the criteria of paragraph (c)(1) or (2) of this section, and providers that met the criteria under paragraph (c)(1) or (2) of this section on the publication date of this regulation unless the provider lost its status under paragraph (c)(1) or (2) of this section thereafter as a result of violating Federal law: (1) Health care providers defined in section 340B(a)(4) of the PHS Act; and (2) Providers described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Public Law 111– 8.

(d) *Payment rates.* Nothing in paragraph (a) of this section shall be construed to require a QHP issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer.

(e) *Payment of federally-qualified health centers.* If an item or service covered by a QHP is provided by a federally-qualified health center (as defined in section 1905(l)(2)(B) of the Act) to an enrollee of a QHP, the QHP issuer must pay the federally-qualified health center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Act for such item or service. Nothing in this paragraph (e) would preclude a QHP issuer and federally-qualified health center from mutually agreeing upon payment rates other than those that would have been paid to the center under section 1902(bb) of the Act, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer indicated in paragraph (d) of this section."

Providers Defined in Section 340B(a)(4) of the PHS Act

(4) ‘‘Covered entity’’ defined

In this section, the term ‘‘covered entity’’ means an entity that meets the requirements described in paragraph (5) and is one of the following:

(A) A Federally-qualified health center (as defined in section 1905(*l*)(2)(B) of the Social Security Act [42 U.S.C. 1396d(*l*)(2)(B)]).

(B) An entity receiving a grant under section 256a 1 of this title.

(C) A family planning project receiving a grant or contract under section 300 of thistitle.

(D) An entity receiving a grant under subpart II 1 of part C of subchapter XXIV of this chapter (relating to categorical grants for outpatient early intervention services for HIV disease).

(E) A State-operated AIDS drug purchasing assistance program receiving financial assistance under subchapter XXIV of this chapter.

(F) A black lung clinic receiving funds under section 937(a) of title 30.

(G) A comprehensive hemophilia diagnostic treatment center receiving a grant under section 501(a)(2) of the Social Security Act [42 U.S.C. 701(a)(2)].

(H) A Native Hawaiian Health Center receiving funds under the Native Hawaiian Health Care Act of 1988.

(I) An urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act [25 U.S.C. 1651 et seq.].

(J) Any entity receiving assistance under subchapter XXIV of this chapter (other than a State or unit of local government or an entity described in subparagraph (D)), but only if the entity is certified by the Secretary pursuant to paragraph (7).

(K) An entity receiving funds under section 247c of this title (relating to treatment of sexually transmitted diseases) or section 247b(j)(2) 1 of this title (relating to treatment of tuberculosis) through a State or unit of local government, but only if the entity is certified by the Secretary pursuant to paragraph (7).

Providers Defined in Section 340B(a)(4) of the PHS Act - Continued

(L) A subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(B)]) that— (i) is owned or operated by a unit of State or local government, is a public or private non-profit corporation which is formally granted governmental powers by a unit of State or local government, or is a private non-profit hospital which has a contract with a State or local government to provide health care services to low income individuals who are not entitled to benefits under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] or eligible for assistance under the State plan under this subchapter; (ii) for the most recent cost reporting period that ended before the calendar quarter involved, had a disproportionate share adjustment percentage (as determined under section 1886(d)(5)(F) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(F)]) greater than 11.75 percent or was described in section 1886(d)(5)(F)(i)(II) of such Act [42 .S.C. 1395ww(d)(5)(F)(i)(II)]; and (iii) does not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement.

(M) A children's hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(iii) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(B)(iii)], or a free-standing cancer hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(v) of the Social Security Act, that would meet the requirements of subparagraph (L), including the disproportionate share adjustment percentage requirement under clause (ii) of such subparagraph, if the hospital were a subsection (d) hospital as defined by section 1886(d)(1)(B) of the Social Security Act.

(N) An entity that is a critical access hospital (as determined under section 1820(c)(2) of the Social Security Act [42 U.S.C. 1395i–4(c)(2)]), and that meets the requirements of subparagraph (L)(i).

(O) An entity that is a rural referral center, as defined by section 1886(d)(5)(C)(i) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(C)(i)], or a sole community hospital, as defined by section 1886(d)(5)(C)(iii) of such Act, and that both meets the requirements of subparagraph (L)(i) and has a disproportionate share adjustment percentage equal to or greater than 8 percent.