

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

Work Group Meeting – Essential Community Providers, Meeting 2
October 22, 2012



MERCER

OLIVER WYMAN

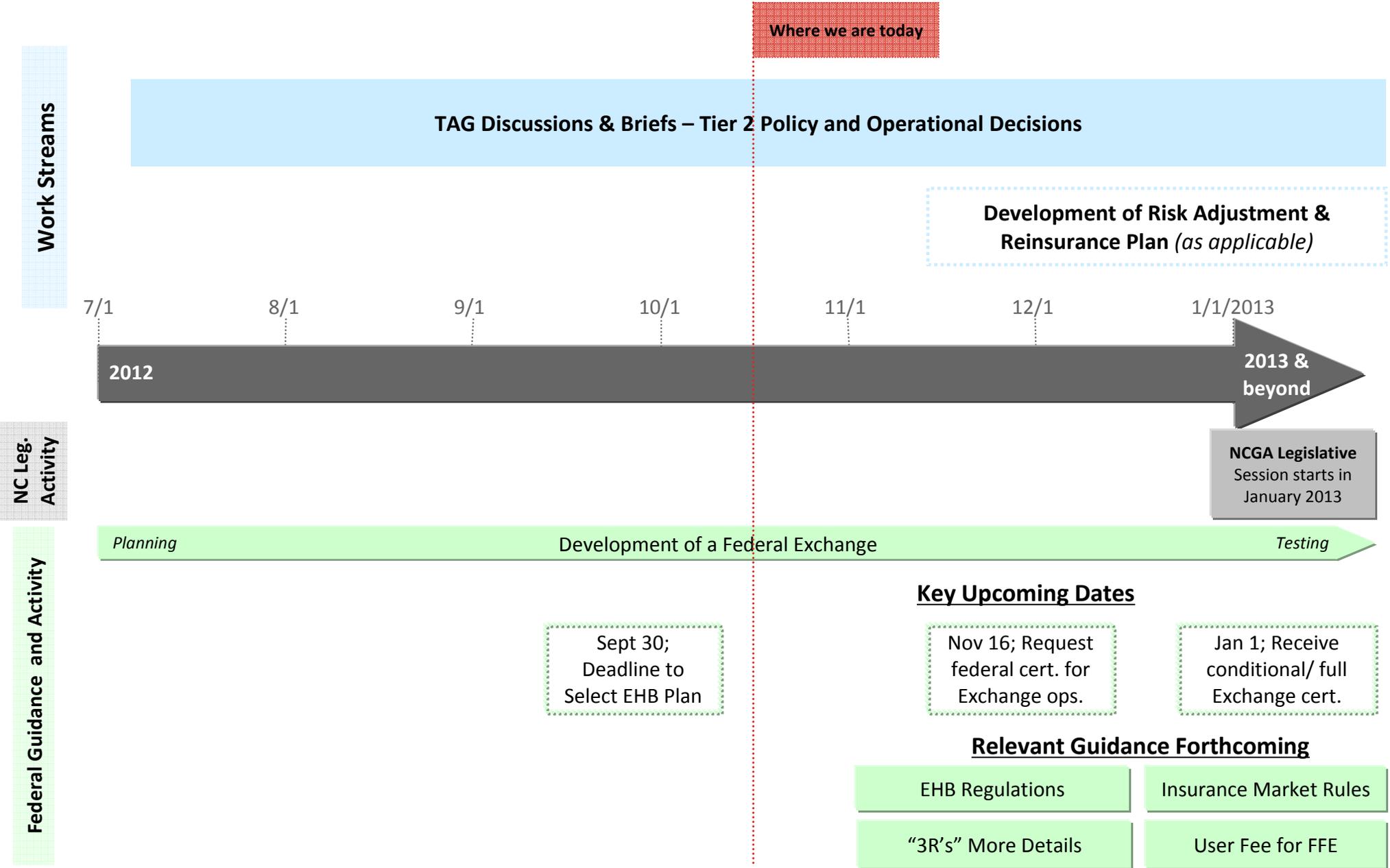
Agenda

9:30 – 9:40	Welcome and Introductions
9:40 – 9:50	Goals/Objectives of Work Group and Today’s Discussion
9:50 – 10:45	Items for Discussion in ECP Work Group: <ul style="list-style-type: none">• Defining Essential Community Providers in North Carolina
10:45 – 11:00	<i>Break</i>
11:00 – 12:15	Items for Discussion in ECP Work Group <ul style="list-style-type: none">• Defining a “sufficient number and geographic distribution” of ECPs to ensure “reasonable and timely access” for “low income, medically underserved individuals” in North Carolina
12:15-12:30	Wrap Up and Next Steps

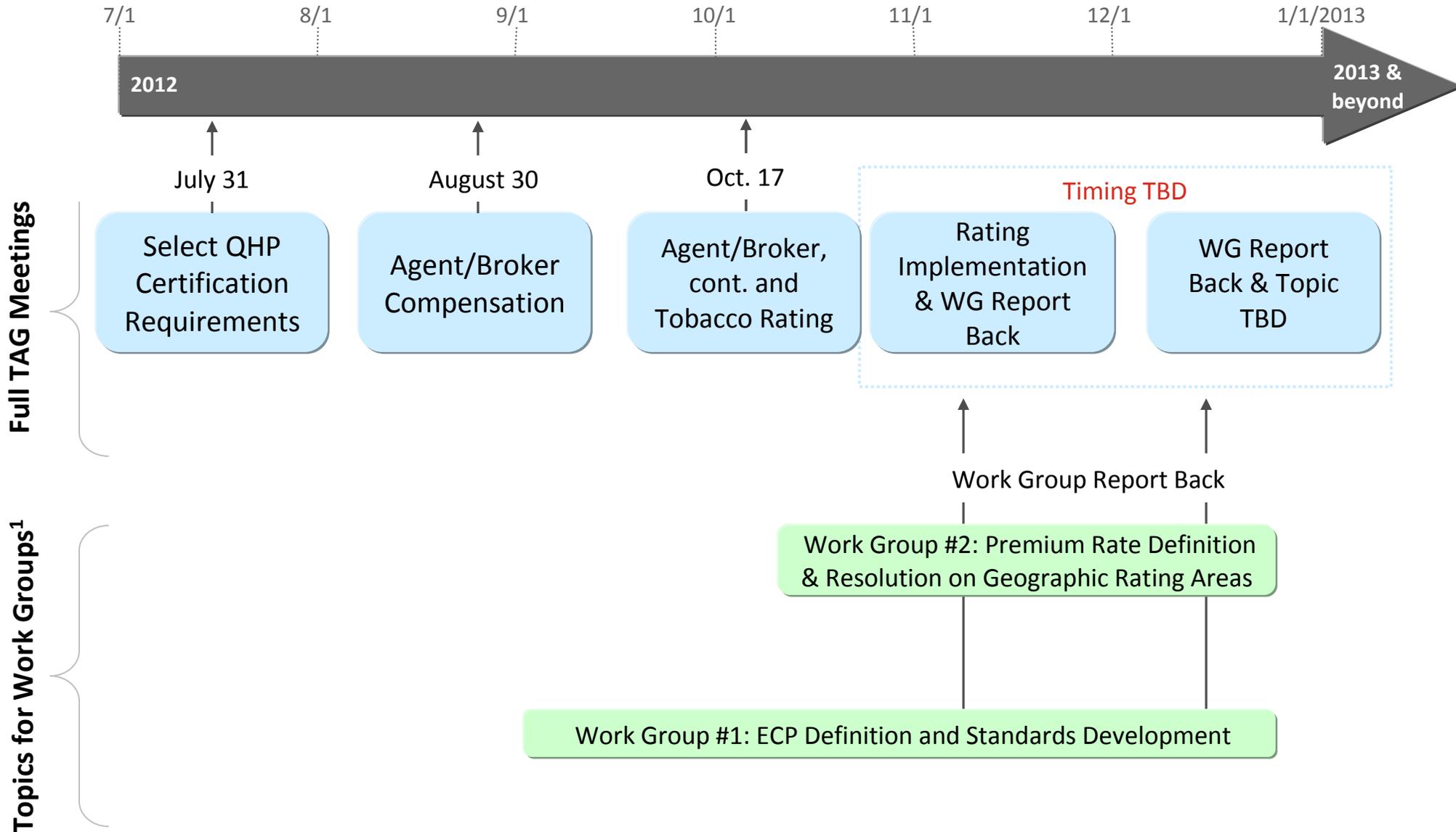
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Current Project and Regulatory Timeline



Tentative TAG Meeting and Work Groups Planning for 2012



¹Work Groups will be held as needed to address technical issues and to arrive at options to set before the TAG.

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

- Identify Essential Community Provider Options to Set Before the TAG for Consideration including:
 - Definition of ECP Providers for North Carolina
 - Processes/Procedures to Evaluate Network Adequacy Standards for ECP Providers

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
- The work group will identify policy options/considerations for the TAG; the TAG, in turn, will make recommendations to the NC DOI, who will develop recommendations, as applicable, to the NCGA
 - Options/considerations can also be based on an interim versus long-term basis
- 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

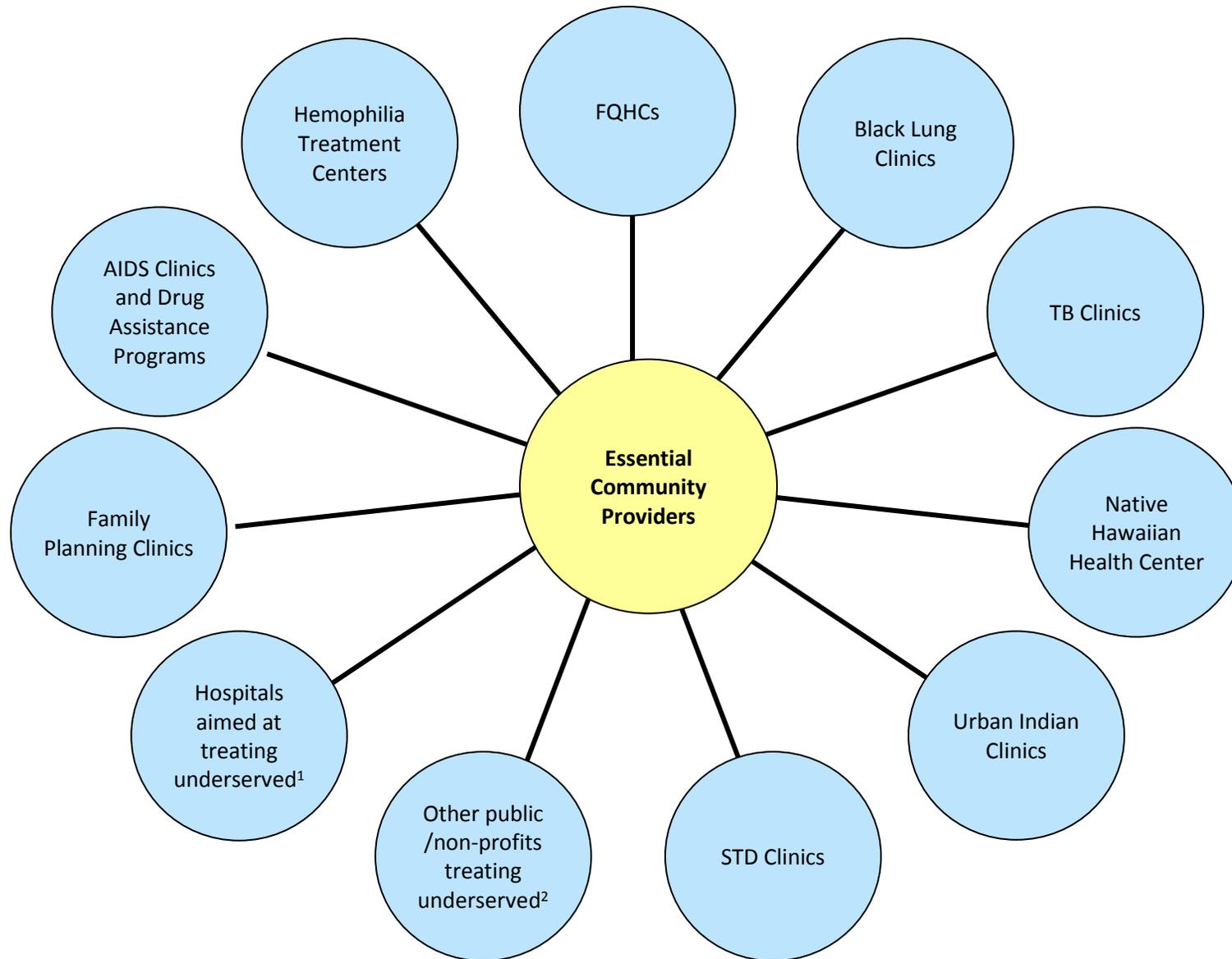
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Relevant Federal Laws and Regulations – Defining ECPs

- ECPs are defined as non-profit providers that serve predominately low-income, medically underserved individuals. (45 CFR §156.235(c)(1))
 - ECPs includes 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 (e.g.- non-profit providers)
- 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. (§156.235(a)(1))
- 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))

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)

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>

In the prior meeting, the work group discussed developing a list to identify all ECP providers in the state but did not resolve whether changes to the ECP definition are needed.

1. Are there providers, while not specified in federal statute, who should fall within the definition of ECPs in North Carolina?

Workgroup members will work to develop as comprehensive a list as possible of providers in North Carolina who might be considered essential community providers to help inform the decision of who should fall within the definition of ECPs in the state. The list will seek to incorporate the several variables identified as critical to creating a provider network that it is sufficiently broad to meet the needs of the target population (e.g., categories of services provided, proportion of uninsured/Medicaid patients served, etc.).

ECP List – Initial Fields & Work Completed to Date

- Counties served
- Type of agency (e.g., FQHC, hospital outpatient, rural health clinic, etc.)
- Percent of unduplicated patients seen in January 2012 who
 - Were Medicaid/NC Health Choice patients
 - Were uninsured
 - Had incomes below 200% FPG
- Organization’s FY 2011 total unduplicated patients seen
- Whether the organization provides the following services and how many hours a week it offers such services
 - Comprehensive primary care services (e.g., preventive, primary acute)
 - » Does the organization limit these services to specific populations (e.g., children, adults)?
 - Prenatal care and delivery services
 - Dental services
 - Behavioral health services (e.g., mental health, substance abuse)
 - Specialty services (e.g., endocrinology, gastroenterology, neurology, cardiology)
- Capacity to accept new patients
- Health insurers or provider networks for which the provider is considered in-network

Please refer to the handout and spreadsheet for additional information

Considerations for Further Refinement of the Definition of ECPs

Federal statute allows any non-profit provider who serves predominantly low-income & medically underserved populations to be considered an ECP. Attempts to enumerate additional categories of ECP providers could ensure there is no ambiguity around additional providers for inclusion, but may also create a false sense of an exhaustive list- which may be premature at this time.

Pros from enumerating definition in State Statute

- Could ensure that there is no ambiguity around additional groups for inclusion
- Could raise profile of lesser-known groups for inclusion in QHP network contracting
- Others?

Cons from enumerating definition in State Statute

- May create a false sense of providers being “in” versus “out” during a time when not all providers are known
- May be of limited value, since ECP designation does not mean insurers must contract with a specific ECP
- Others?

Draft Work Group Statement: Defining ECPs in North Carolina

The below statement is a draft for the work group's consideration.

The State should adopt the expansive federal definition of an ECP provider at this time, as it does not limit the type of provider included for ECP consideration.

- Keeps existing broad definition

Per Federal regulations, ECPs are non-profit providers that serve predominantly low-income, medically underserved individuals, including, but not limited to, providers meeting the criteria defined in Section 340(b) of the PHS Act

- “Plain English” language for ACA

North Carolina should define “serve predominantly low income, medically underserved individuals” in the following way:

- *provider organization has a client mix that is > 50% of Medicaid/CHP, uninsured and/or low income individuals with incomes at <250% of the FPL*

- Further defines thresholds for ECP inclusion that any provider could evaluate

Development of an ECP Registry for North Carolina

The initial list could serve as the foundation for a broader effort to identify ECPs in North Carolina

- Opportunity to continue effort to identify ECPs- particularly those who are not identified in the 340(b) statute
- Any provider who meets the definition of an ECP could be added to the list
- A registry could help insurers identify where ECPs are located and the types of services they provide
- Insurers may also have insight into ECP providers they are contracting with, and could encourage providers to be added to the registry
- The North Carolina Department of Insurance could leverage the ECP list when performing network adequacy reviews for inclusion of ECPs *(as applicable as part of the QHP certification process)*

Draft Work Group Statement: Proposal for Registry Process

The below statement is a draft for the work group's consideration.

North Carolina should build on the current efforts to develop a registry of ECP providers in the state. Any provider who meets the definition of an ECP can be added to the list.

- Centralizes list of ECP providers
- Allows providers to be added to the list

The registry will be made publicly available and is not proprietary.

- Insurers can use the list for ECP contracting
- NC DOI can access the list for QHP certification, etc.

Providers can seek to have themselves added to the list. Insurers, through network contracting efforts, could inform providers of the registry and encourage registry participation.

- Establishes process by which providers could be added for inclusion

*Other comments for work group consideration on
defining Essential Community Providers in North Carolina?*

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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 non-profit 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))

North Carolina Existing Statute & Administrative Code

- NC Statute defines health insurers¹ 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.)

- **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)*

- **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 statute is likely sufficient for meeting ACA network adequacy requirements for QHPs, with the exception of Essential Community Providers.

In the prior meeting, the work group agreed to continue the discussion of establishing ECP-specific Network Adequacy Standards.

1. 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”?
 - The group will continue its assessment, keeping in mind open issues identified in the discussion, including:
 - which population should be included in the denominator of network adequacy measures targeting low-income and medically underserved individuals;
 - how to ensure that a broad range of provider types and services are captured in network adequacy measures; and
 - what types of standards are most effective and thus potentially worth prioritizing.

Common Measures Used to Assess Network Adequacy

There are common measures used to assess adequacy, but not a set of metrics which are agreed upon to set network adequacy standards.

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- Standards Reporting

North Carolina currently requires insurers to set their own adequacy standards in an uniform format

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
- Most HMOs/PPOs also distinguish against geographic designation (rural/urban/suburban) but it is not required

 = Insurer-set network adequacy standards

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

North Carolina Network Adequacy Reporting- Provider Counts

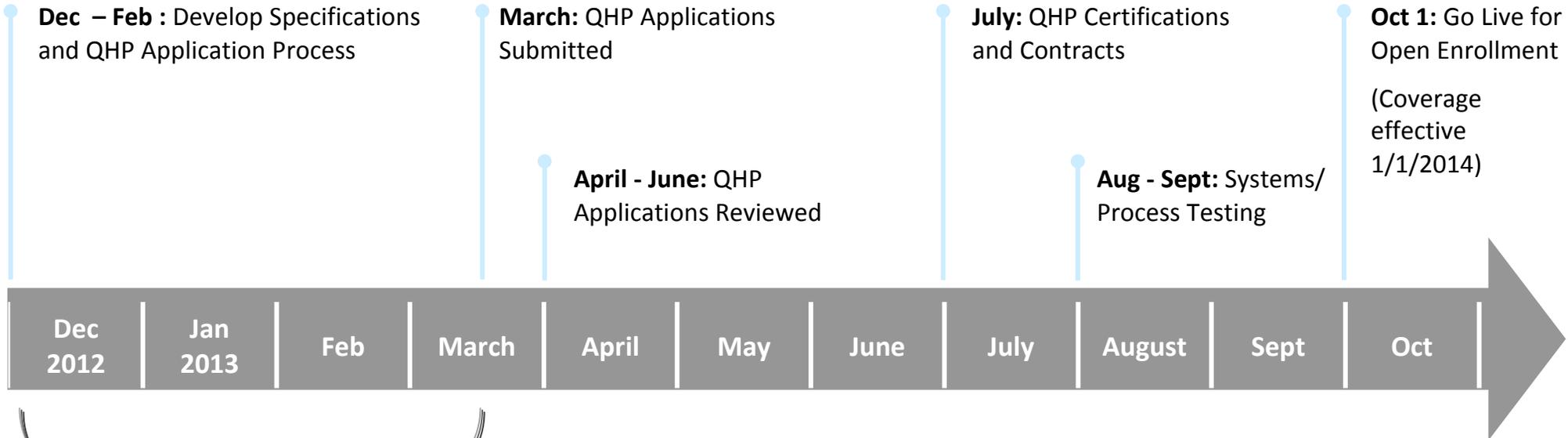
In addition to network adequacy standards, insurers are also required to report on the number of provider types by county

Insurer	County	PCPs	Pediatricians	Ob/Gyn	Specialist Physicians	Non-MD Providers	Inpatient Facilities	Outpatient Facilities	MH/CD Providers	MH/CD Providers	MH/CD Inpatient Services
1	Alamance	57	19	16	92	43	1	21	3	10	1
	Alexander	15	0	0	12	7	0	1	0	0	0
	Alleghany	7	0	0	1	1	1	1	1	1	0
2	Alamance	51	18	10	126	71	1	2	4	30	2
	Alexander	12	0	0	0	12	0	0	0	3	0
	Alleghany	7	0	0	14	7	1	1	0	4	0
3	Alamance	99	20	13	223	28	6	27	5	16	1
	Alexander	17	0	0	15	8	1	1	0	1	0
	Alleghany	8	0	0	5	2	2	2	2	2	0

- North Carolina HMOs/PPOs report across the same provider types
- North Carolina does not set specific enrollee to provider ratios, but requires reporting of those ratios

Source: North Carolina Department of Insurance; Requirements apply to PPOs as well

Key Dates for State in Year One Timeline



Limited timeframe for insurers to contract with ECPs, in addition to other QHP requirements

Considerations for Setting ECP Network Adequacy Standards

Existing process of requiring insurers to define their own standards, as opposed to a state-defined standard across all insurers, appears to be a viable in light of challenges. Additional parameters could be considered for ECP network adequacy reporting and evaluation.

Pros of requiring that insurers set ECP standards

- Allows time for further evaluation of ECP providers/services and target population
- Possible under existing timelines & aligned with current state regulation
- Others?

Cons of requiring that insurers set ECP standards

- May not adequately address network adequacy concerns for ECP population
- Others?

The work group will next consider what those parameters will be.

Further Defining Parameters Specific to ECPs

Parameter 1:

Illustrative ECP Standards Example

1 ECP PCP per
1,500 members of
target population

Provider Ratio

2 ECP Providers
within 10 miles of
the target
population

Time/Distance

- Require that ECP standards set by insurers take into consideration:
 - The specific numbers of the low income, medically underserved individuals either projected to be covered by the insurer, or actually covered by the insurer
 - Only ECP providers- as designated on the registry or added to the registry by insurers

Further Defining Parameters Specific to ECPs

Parameter 2:

Current Network Reporting, by Specialty

PCP	Pediatric	OB/Gyn	Specialist	Non-MD	Acute Facility	Out patient Facility	Mental Health	Mental Health non-MD	Mental Health Facility
									

- Require insurers to report ECP standards and provider counts across specific specialty areas already used for reporting of network adequacy
- Discussion could be had on which providers should be reported for ECPs, specifically

 = Would likely be included for ECP-specific reporting

 = Could be considered for ECP reporting

Further Defining Parameters Specific to ECPs

Parameter 3:

- Allow insurers to have exceptions to ECP coverage, as permitted under federal law
- Examples of viable exceptions include:
 - ECP provider availability
 - *“A QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timeliness access...” (45 CFR 156.235(a))*
 - ECP refuses to contract and rates were generally applicable payment rates
 - *“Nothing....shall required a QHP to contract with an ECP if such provider refuses to accept the generally applicable payment rates of such issuer.” (45 CFR 156.235(d))*
 - Issuer uses an employed model, or is through a single contracted medical group
 - *Issuers must have a sufficient number and geographic distribution of employed or contracted providers and hospital facilities to ensure reasonable and timely access for the target population. (45 CFR 156.235(b))*

Draft Work Group Statement: Interim Establishment of Insurer ECP Standards

The below statement is a draft for the work group's consideration.

The State will require insurers to set network adequacy standards for ECP providers.

- Keeps existing methodology
- Does not preclude longer-term solution or other requirements

Such standards shall be ECP-specific, and be based on the anticipated or actual enrollment of the target population and the number of contracted ECP providers.

- Allows for ECP-specific standards establishment

Insurers will be required to report ECP standards using the existing state-mandated network adequacy reporting process.

- Relies on existing process, and informs comparisons between ECP and non-ECP standards

To the extent Exceptions are permitted under federal law, they will be granted to insurers looking to become QHPs in the North Carolina market.

- Establishes exceptions criteria which would not preclude insurers with valid exceptions from becoming a QHP

Options and Action Steps

Question: Should the NC DOI, in conjunction with ECP providers and insurers, re-evaluate the process after 2 years, for changes effective in 2016?

Options	Action Steps
No	<ul style="list-style-type: none">• Do nothing
Yes	<ul style="list-style-type: none">• Flag for follow up in 2016• Consider conducting a broader study to assess additional options available for establishment of an ECP network adequacy process based on experience in first 2 years

*Other comments for work group consideration on
defining Essential Community Providers Network Adequacy Standards?*

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- **Present Options for TAG discussion/deliberation**

Questions?

GENERAL.—The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum—

include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111–8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;

ECP: Regulations (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 this title.

(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

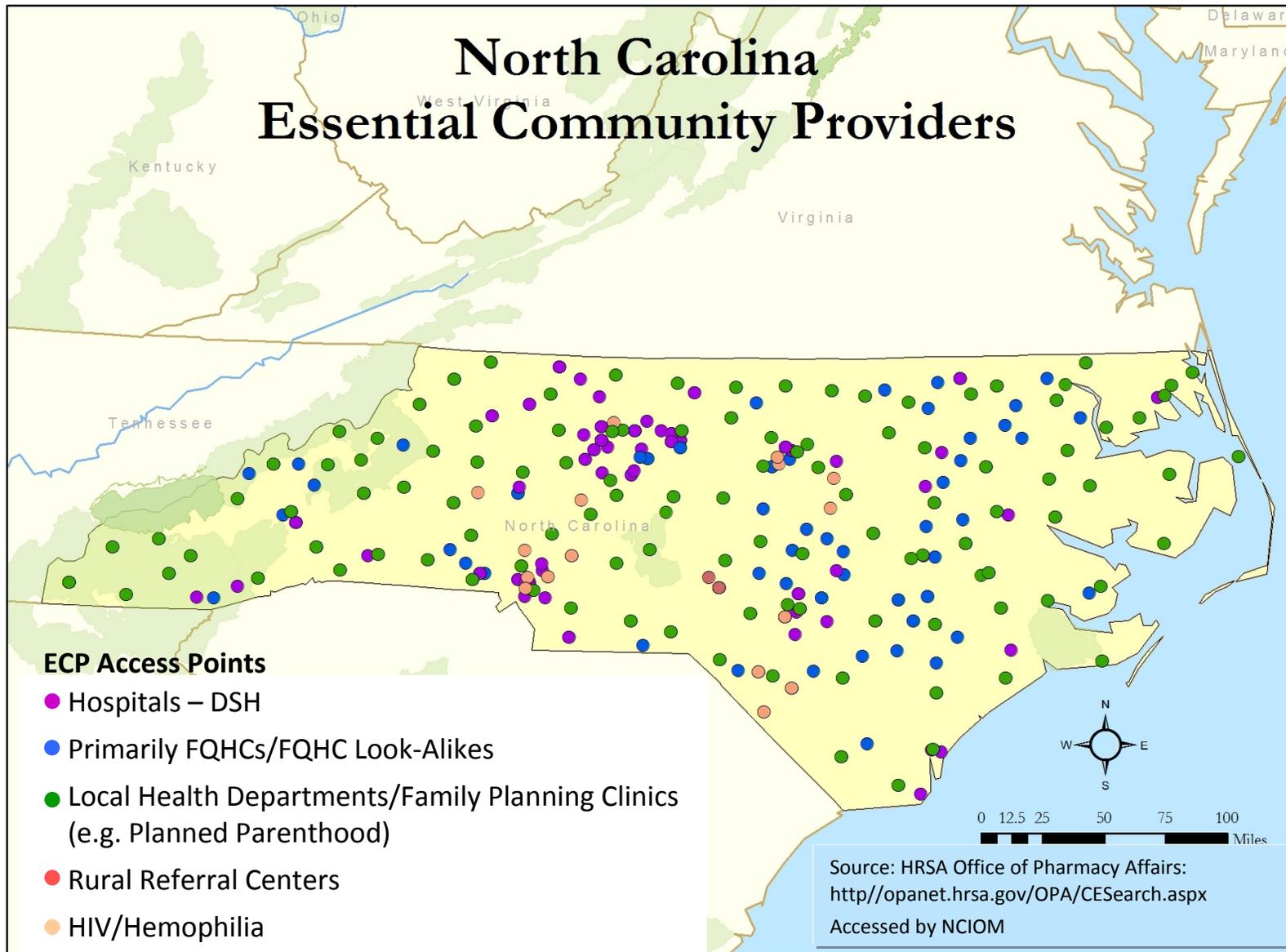
- (L) A subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(B)]) that— (i) is owned or operated by a unit of State or local government, is a public or private non-profit corporation which is formally granted governmental powers by a unit of 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 U.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.

Providers Defined in SSA 1927(C)(1)(D)(i)(IV)

An entity that—

- (aa) is described in section 501(c)(3) of the Internal Revenue Code of 1986[476] and exempt from tax under section 501(a) of such Act or is State-owned or operated; and
- (bb) would be a covered entity described in section 340B(a)(4) of the Public Health Service Act insofar as the entity described in such section provides the same type of services to the same type of populations as a covered entity described in such section provides, but does not receive funding under a provision of law referred to in such section

Geographic Distribution of ECPs in North Carolina



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

ECPs in North Carolina – As Defined by Statute

Provider Type	Description	Number of Providers
<p>FQHC</p>	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 34 at nearly 160 different sites
<p>Local Health Departments</p>	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 85 local public health departments in North Carolina <ul style="list-style-type: none"> • 79 single-county • 6 multi-county
<p>Planned Parenthood</p>	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 9 locations

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

Provider Type	Description	Number of Providers
<p>Ryan White Clinics and AIDS Drug Assistance Program</p>	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Part A: 1 program • Part B: 6 programs • Part C: 12 programs • Part D: 7 programs
<p>Hemophilia Clinic</p>	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 2 locations

Other Potential ECP Entities

Provider Type	Description	Number of Providers
Rural Health Centers	<ul style="list-style-type: none"> • Located in areas with limited primary care resources • Provide primary care and routine diagnostic and therapeutic care • Some provide dental and behavioral health services 	<ul style="list-style-type: none"> • 86 federally certified centers • 19 state-funded centers
School Based/Linked Health Centers	<ul style="list-style-type: none"> • Provide primary care, mental health, acute and chronic disease management, immunizations, medical exams, sports physicals, nutritional counseling, health education, prescriptions, and medication administration 	<ul style="list-style-type: none"> • 55 centers
Other Non-Profits Aiming to Treat Uninsured	<ul style="list-style-type: none"> • Example: North Carolina Community Care Network which is aimed at managing care for the Medicaid population 	<ul style="list-style-type: none"> • 14 Community Care Networks