North Carolina Department of Insurance
Essential Community Provider (ECP) Workgroup Meeting
Thursday, August 30, 2012
FINAL version – approved by the WG via email

Meeting Attendees	Organization
Workgroup Members and NC DOI Project Team	
Barbara Morales Burke	Blue Cross Blue Shield of North Carolina
Tracy Baker	Coventry Health Care of the Carolinas, Inc.
Ken Lewis	FirstCarolinaCare Ins. Co. Inc.
Tom Bennett	Hemophilia of North Carolina
Allison Rice	Duke University School of Law
Allison Garcimonde	Manatt
Sharon Woda	Manatt
Melinda Dutton	Manatt
Joel Ario	Manatt
Rebecca Whitaker	NC Community Health Center Association
Ted Hamby	NC Department of Insurance
Jean Holliday	NC Department of Insurance
Julia Lerche	NC Department of Insurance
Lauren Short	NC Department of Insurance
Allen Feezor	NC Department of Health & Human Services
Jacquelyn Clymore	NC Department of Health & Human Services
Evelyn Foust	NC Department of Health & Human Services
Joy Reed	NC Division of Public Health, DHHS
Pam Silberman	NC Institute of Medicine
Adam Linker	NC Justice Center
Linwood Jones	NC Hospital Association
Chris Collins	NC Office of Rural Health & Community Care, DHHS
John Price	NC Office of Rural Health & Community Care, DHHS
Paige Johnson	Planned Parenthood of Central North Carolina
Susan Davis	Community Care of Wake/Johnston Counties

Agenda

- Welcome and Introductions
- Goals/Objectives of Workgroup and Today's Discussion
- Update on "Essential Community Providers" under Final Federal Exchange Rules & Current State Statute
- Items for Discussion in ECP Workgroup
  - *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? Are there any other options around identification of ECPs in North Carolina that the work group should consider?*
  - *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?*
- Wrap Up and Next Steps

Please refer to the August 30 "ECP Work Group" Slide Deck.

- The ECP Workgroup has been convened as a subgroup of the NC DOI's Technical Advisory Group ("TAG") to bring individuals together with specific technical expertise to help inform the TAG's deliberations around the definition of ECPs in North Carolina and related standards.
- The goal of the ECP Workgroup will be to develop policy options and approaches to meeting ECP requirements for broader TAG consideration. The TAG, in turn, will recommend preferred options to the NC DOI, who will develop recommendations as applicable to the North Carolina General Assembly ("NCGA").

Issues for Discussion in ECP Workgroup

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? Are there any other options around identification of ECPs in North Carolina that the work group should consider?

- The Workgroup reviewed relevant federal and state law and regulations related to ECPs. Members noted that the terms "low-income" and "medically underserved" are not defined in the ACA but critical to determining who should fall within the definition of ECPs in North Carolina. Similarly, "generally applicable rate" is not defined and generally has been interpreted to mean whatever is generally paid in the marketplace. This rate could be based on the standard fee schedule; however, this may prove to be a point of contention when implementing the provision as small community providers typically do not have access to, and large health systems in the state are not on, the standard fee schedule.
- To inform its assessment of providers who would currently be considered ECPs in North Carolina under the ACA, the group reviewed a spreadsheet compiled by the NC Institute of Medicine

("IOM") which listed those entities in the state considered to be 340B providers. Members agreed that clarification is needed to determine whether entities need merely to meet the criteria to receive 340B funding, or actually be receiving 340B funds, to be included.

- The group turned to discuss whether additional provider types beyond those specified in federal statute should be included in the definition of ECPs in North Carolina. Member observations included the following:
    - Not-for-profit free clinics that begin to charge for services as previously uninsured individuals secure health coverage could be included in the definition of ECPs.
    - As North Carolina still has large rural areas, rural health clinics play a critical role in providing access to care and should be considered for inclusion (including those clinics that do not necessarily meet the criteria established in Public Law 95-210). Additionally, many of these clinics are successfully funded with state dollars such that it will be important to assess the implications for displacement of current state funds.
    - The North Carolina Indian American Indian Health Center is interested in being considered for inclusion in the ECP definitions.
    - Mental health and substance abuse nonprofit providers should be considered for inclusion.
    - Not all nonprofit entities (e.g., hospitals) focus primarily on providing services to low-income individuals, such that the definition of ECPs should not necessarily include by default all non-profit entities in the state.
    - In the case of a 340B entity that contracts with affiliated providers (e.g., a 340B hospital and affiliated clinics), it is unclear whether the 340B designation also applies to the affiliated providers or solely to the 340B entity.
    - Carriers have limited provider contracting capacity as the contracting process is administratively burdensome and very time-consuming. Accordingly, the group should be mindful of making the definition of ECPs overly broad because the more the list of ECPs is expanded, the longer it will take carriers to contract with all the providers listed and the less likelihood there will be that carriers will be able to determine which providers should be prioritized in the contracting process (i.e., which providers should be "at the top of the list"). For this reason, it will be critically important to categorize the list of ECPs in some way, such as by the type of services provided, in order to ensure that all services are covered in as many geographical areas as possible. However, it is equally important to note that there are some types of services that require large numbers of providers to protect the public health (e.g., TB, AIDS/STD clinics).
    - The extent to which potential ECPs have the capacity to contract with commercial carriers may inform prioritization of providers in the near-term as part of a rollout approach (e.g., Do they have providers who will meet carriers' credentialing requirements? Do they have internal administrative systems that can support contracting and billing?). The Community Care Network of North Carolina might be considered as a potential vehicle to assist certain types of providers to prepare for the commercial contracting process.
    - Because a large percentage of children seek care through school-based clinics ("SBCs"), and because these clinics serve as a primary source of care for children without private insurance, they should be considered for inclusion. However, many SBCs are sponsored by other 340B entities which goes back to the question of whether 340B designations apply only to the primary entity or to its affiliates as well.

  - In considering whether Medicaid providers should be included in the definition of ECPs, it is important to distinguish between those providers that have historically provided services to a large number of Medicaid beneficiaries and those who see only a small number of Medicaid beneficiaries on an inconsistent basis. Accordingly, it will be worthwhile to determine the proportion of Medicaid beneficiaries seen by potential ECPs. Of note, there are some for-profit providers who serve a large number of Medicaid patients which may point to a need to consider how to handle for-profit providers serving the Medicaid and other underserved populations. Providers who have elected to participate in the Medicaid Electronic Health Record Incentive Program will have these percentages available due to related program requirements.
  - Because a primary goal of health reform efforts is to expand coverage to the previously uninsured, it will also be critical to determine the proportion of uninsured individuals historically served by providers under consideration for inclusion in the definition of ECPs.
- Based on this discussion, the group agreed that as a first step it should work to pull together as comprehensive a list as possible of providers in the state who might be considered for inclusion in the definition of ECPs (including those that do or do not meet 340B criteria) to inform the group's development of policy options for finalizing the definition.

Follow-Up Items:

  - 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.).
  - The group will seek additional information on open policy questions including:
    - whether a 340B designation applies only to the 340B entity or if it also applies to its affiliates;
    - whether action needs to be taken around building provider capacity to ensure that providers are well-positioned to contract with commercial carriers in a post-2014 environment; and
    - issues related to the displacement of state funds that are currently being used to fund providers who in the future might potentially be included in the definition of ECPs.

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?

- The Workgroup reviewed relevant federal and state laws related to network adequacy, as well as common measures used to assess network adequacy and measures currently used by carriers in North Carolina.

- The group discussed whether and the extent to which North Carolina should require QHPs to set their own network adequacy standards/specific measures or establish a common set of standards/specific measures that QHPs must meet. Member observations included the following:
    - In considering whether and how to develop network adequacy standards to ensure that low-income populations and medically underserved populations are adequately served, it will be important to determine who should be included in the denominator of the measure – i.e., is the denominator the entire population being served, or does it only include the low-income and medically underserved? If the latter, and as previously discussed, it will be necessary to clearly define the terms "low-income" and "medically underserved."
    - Geographic accessibility standards (e.g., a plan must make at least 2 primary care providers available within 30 miles of an enrollee) are the easiest types of standards for carriers to calculate and monitor. Other types of standards, such as in-office waiting times, are difficult to track and in some ways outside of the carriers control. Additionally, as the demand for services increases due to the post-2014 coverage expansion, it will impact appointment and in-office waiting times; conversely, new models of care (such as Accountable Care Organization) might create additional capacity that better facilitate timely access to care. It is unclear how the impact of these reforms should impact specific standards for timely access.
    - Carrier representatives stated that many insurers try to approach the network adequacy issue from a "global" perspective, or to facilitate access for the entire community. However, the group noted that this would make it challenging to target subpopulations and monitor their access. Carrier representatives responded that the best way to address this issue might be to distinguish ECPs as a separate provider type within network adequacy standards. Several members countered that, as previously discussed, the universe of provider types that might fall in the definition of ECP is very broad such that ensuring that a certain number of ECPs are available in a geographical area will not ensure that that the full range of services offered by ECPs are available in the area (i.e., if you have 2 ECPs within 30 miles, this does not guarantee that you will have an HIV provider, a mental health and substance abuse provider, etc.).
- Based on this discussion, the group agreed that additional assessment of the issue is required.

Follow-Up Items

- 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.

Next Steps

- The NC IOM will develop a template to collect information on the potential universe of ECPs in the state and circulate to workgroup members to review and complete the template for the constituencies they represent.
- DOI and Manatt team will take feedback from the meeting and develop more detailed information on potential policy options for the workgroup's consideration at its next meeting.
- Workgroup members are encouraged to send any additional feedback or suggestions to Allison Garcimonde (agarcimonde@manatt.com) or Lauren Short (lauren.short@ncdoi.gov) of the NC DOI.