North Carolina Department of Insurance
Essential Community Provider (ECP) Workgroup Meeting
Monday, October 22, 2012-- FINAL

Meeting Attendees	Organization
Workgroup Members and NC DOI Project Team	
Linda Kinney	Care Share Health Alliance
Susan Davis	Community Care of Wake/Johnston Counties
Tracy Baker	Coventry Health Care of the Carolinas, Inc.
Allison Rice	Duke University School of Law
Ken Lewis	FirstCarolinaCare Ins. Co. Inc.
Tom Bennett	Hemophilia of North Carolina
Allison Garcimonde	Manatt
Sharon Woda	Manatt
Joel Ario	Manatt
Rebecca Whitaker	NC Community Health Center Association
Rosemary Gillespie	NC Department of Insurance
Ted Hamby	NC Department of Insurance
Julia Lerche	NC Department of Insurance
Ben Popkin	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
Mike Schwartz	NC Division of MHDDSAS, DHHS
Pam Silberman	NC Institute of Medicine
Adam Linker	NC Justice Center
John Price	NC Office of Rural Health & Community Care, DHHS
Connie Parker *(by phone)*	NC School Community Health
Paige Johnson	Planned Parenthood of Central North Carolina
Melissa Reed *(by phone)*	Planned Parenthood Health Systems

Agenda

- Welcome and Introductions
- Goals/Objectives of Workgroup and Today's Discussion
- Items for Discussion in ECP Workgroup
  - *Defining ECPs in North Carolina*
  - *Defining a "sufficient number and geographic distribution" of ECPs to ensure a "reasonable and timely access" for "low income, medically underserved individuals" in North Carolina*
- Wrap Up and Next Steps

Please refer to the October 22 "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

Defining ECPs in North Carolina

- The Workgroup briefly reviewed relevant federal and state law and regulations related to ECPs, and prior workgroup discussions on the ECP issue. At the Workgroup's previous meeting, the group discussed developing a list to identify potential ECPs in the state and to inform discussion of which providers might fall within the state's ECP definition. To this end, the North Carolina Institute of Medicine distributed a survey to potential ECPs in the state and began to develop a spreadsheet of providers with data collected regarding type of organization (e.g., local health department, FQHC, hospital outpatient), counties served, type of services provided, patient mix (i.e., percent of patients who are Medicaid/CHIP beneficiaries, uninsured or low-income individuals with incomes below 200% FPL), capacity to accept new patients and to accept commercial insurance. The group noted that this might serve as the start of a state registry of providers who fall within the definition of ECPs, once the definition is finalized.
- The Workgroup reviewed the policy options under consideration for North Carolina's further refinement of the ECP definition. Members were then asked to review and discuss the following draft workgroup statements regarding a proposed approach for 1) defining ECPs in the state and 2) establishing an ECP registry process:

Draft Workgroup Statement: Defining ECPs in North Carolina

- The State should adopt the expansive federal definition of an ECP at this time, as it does not limit the type of provider included for ECP consideration.
- 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.
- North Carolina should define "serve predominantly low income, medically underserved individuals" in the following way:
    - Provider organization with a client mix that is > 50% Medicaid/CHIP, uninsured and/or low-income individuals with incomes at or below 250% FPL.

Draft Workgroup Statement: Proposal for ECP Registry Process

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

Discussion of Draft Workgroup Statements

- In response to a question, meeting facilitators from Manatt and the NCIOM clarified that the federal statutory definition of ECP identifies 340B providers and non-profit providers serving predominantly serving low-income, medically underserved individuals as falling within the ECP definition, but does not limit it to these types of providers such that for-profit providers are not precluded from inclusion.
- Members noted that a benefit of adopting the expansive federal definition of ECP at this time is that a broader universe of ECPs will give carriers more providers from which to choose when building QHP networks. Carrier representatives responded that their support for a broad definition and expansive universe of ECPs is in part dependent upon related network adequacy metrics (i.e., will carriers be required to contract with all ECPs meeting the definition? How will adequacy be measured and what data will carriers be required to report?). Carriers also noted that an expansive list of ECPs could prove overly burdensome to carriers seeking to newly enter the market if required to contract with all ECPs.
- The group discussed the proposed definition of what constitutes a provider who "predominantly serves low-income, medically underserved individuals" and agreed that the draft workgroup statement should be modified to clarify that, for the purposes of meeting the proposed client mix requirement, providers can use a combination of Medicaid/CHIP, uninsured and low-income patients to meet the greater than 50% threshold. Meeting facilitators also clarified that "low-income individuals" had been defined in the draft workgroup statement as those with incomes at or below 250% FPL because this aligns with the ACA-established eligibility threshold for reduced cost-sharing in the Exchange.
- Members discussed the operational challenges associated with ensuring that ECPs meet definitional requirements for initial inclusion on the ECP registry, as well as with monitoring the registry on an ongoing basis to ensure that it remains accurate and up-to-date. Some members noted that many ECP-type providers already collect information on household income that could be used for assessing eligibility for the ECP designation, and that many

providers also track client mix as a condition of participation in the Medicaid Electronic Health Record Incentive Program. Some members expressed concern that including uninsured patients in the client mix could result in inaccuracies, as this could also potentially make eligible providers who service uninsured patients who pay for services out of pocket but are not necessarily low-income. However, while recognizing that these operational and data challenges may create some inaccuracies in the registry, the group expressed a desire to avoid making the ECP designation process an onerous one and to minimize the related administrative burden placed on providers and carriers.

- In response to the concern that allowing uninsured patients to be included in the client mix requirement could allow providers who do not predominantly serve low-income individuals to still meet the ECP definition, the group considered whether the definition should include a requirement that ECPs be Medicaid providers in order to validate that the provider serves a low-income population. However, the group ultimately decided against making this a component of the ECP definition as members agreed that it is unlikely that any provider could meet the 50% client mix threshold without offering services to Medicaid beneficiaries, as well as because the requirement could dissuade some providers who serve low-income populations from seeking an ECP designation if they do not wish to participate in Medicaid.
- The group confirmed that providers could either demonstrate they are a 340(B) provider or that they predominantly serve low-income, medically underserved individuals as defined to be included in the registry (such that 340(B) providers would not need to demonstrate they meet the additional criteria and for-profit providers would be eligible for inclusion). Carrier representatives agreed that the registry could be a useful tool to fill identified gaps in QHP networks.

Points of Consensus:

- Workgroup members **reached consensus** to accept the draft workgroup statement regarding the definition of ECPs in North Carolina pending the following modifications:
  - in the second bullet, change “non-profit providers” to say “any providers” and clarify that ECPs are any 340B provider plus any provider that meets specified criteria;
  - in the third bullet, clarify that “client mix” can be determined by a combination of Medicaid/CHIP, uninsured and low-income patients.
- Workgroup members **reached consensus** to accept as drafted the draft workgroup statement regarding development of an ECP registry process.

Defining a “sufficient number and geographic distribution” of ECPs to ensure “reasonable and timely access” for “low-income, medically underserved individuals” in North Carolina

- 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 and prior workgroup discussion of the issue. The group then reviewed potential parameters specific to the development of ECP standards and were asked

to consider the following draft workgroup statement regarding a potential process for the interim establishment of insurer ECP standards:

Draft Workgroup Statement: Interim Establishment of Insurer ECP Standards

- The State will require insurers to set network adequacy standards for ECP providers.
- 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.
- Insurers will be required to report ECP standards using the existing state-mandated network adequacy reporting process.
- To the extent exceptions are permitted under federal law, they will be granted to insurers looking to become QHPs in the North Carolina market.

Discussion of Draft Workgroup Statement

- The group noted that the draft workgroup statement incorporated two overarching policy option questions: first, who should set network adequacy standards for ECP providers (the first proposed bullet), and second, whether there are any parameters with which the group believes ECP standards should be required to comply (proposed bullets 2-4).
- Members first discussed the issue of whether insurers should be required to set and meet their own network adequacy standards similar to current practice in the state, or if the state should establish ECP standards with which insurers must comply (bullet one in the draft workgroup statement).
    - Carrier representatives noted that timelines for the provider credentialing and contracting process were very tight, such that, realistically, carriers will have needed to complete the process by January 2013 in order to be ready for QHP enrollment. Members agreed that this would likely leave insufficient time for the state to establish, and carriers to come into compliance, with ECP network adequacy standards.
    - The group discussed potential mechanisms that would allow carriers some flexibility if state-established standards were implemented in recognition of the accelerated timeline, such as allowing carriers to rely on Letters of Intent from ECPs to meet related network adequacy standards (rather than requiring that the full credentialing and contracting process be completed). Carrier representatives noted that Letters of Agreement might be more appropriate than Letters of Intent, as the former contains more substance around contract provisions than the latter.
    - The group also discussed whether carriers might be permitted to employ less stringent credentialing criteria in the near-term for ECPs in order to ensure they are included in QHP networks in sufficient number despite ambitious timelines. Carrier representatives responded that they would be strongly supportive of smarter credentialing processes – such as establishing tools that would prevent each provider having to be independently credentialed by every carrier with whom they contract – but noted that current NCQA accreditation requirements set for credentialing standards as well as the fact that the public interest might not be best served by allowing for laxer credentialing standards.
    - Members discussed the possibility of phasing in ECP network adequacy standards such that more stringent, state-established standards are implemented in later years. The group observed that while this would allow the state to assess whether carrier-

established standards are resulting in an adequate number of ECPs in QHP networks, it might also lend to administrative complexity if standards are modified after 2014.
    - The group ultimately agreed that the short timeline associated with the QHP provider credentialing and contracting process provides insufficient time for the state to set and carriers to comply with state-established ECP network adequacy standards such that, at least initially, carriers should be required to establish their own standards.
- The group then turned to assess potential parameters that could guide carriers' establishment of and reporting on ECP network adequacy standards (bullets 2-4 in the proposed workgroup statement).
    - Workgroup members discussed Parameter 1 and agreed that standards should be ECP-specific and based on the anticipated or actual enrollment of the target population and the number of contracted ECP providers as designated on the ECP registry.
    - The Workgroup then considered Parameter 2, or whether carriers should be required to report ECP standards and provider counts across specific specialty areas already used for reporting of network adequacy in the state (e.g., specialist, mental health, acute or outpatient facilities). Carrier representatives noted that a challenge with requiring insurers to report on ECP adequacy across specialty areas is that this is a new population who will in many cases be receiving coverage for the first time, making it difficult for insurers to have a grasp on which types of specialty services they seek and at what volume in order to determine adequacy standards for ECP specialists. Other members countered that while it may be unfeasible to have a network adequacy standard for every type of ECP specialist that exists, it would be relatively easy to identify ECPs providing primary care (i.e., primary, pediatric and OB/GYN care) and require that they be contracted with in sufficient number to meet commercial network adequacy standards for primary care providers.
    - The Workgroup considered Parameter 3, or whether insurers will be allowed to have exceptions to ECP coverage as permitted under federal law (such as if there are no ECPs available in a given area to ensure sufficient number and geographic distribution, or if an ECP refuses to contract despite the carrier offering generally applicable rates). Members noted that a process may need to be established to determine what constitutes a "generally applicable rate."
- Finally, the Workgroup discussed whether the NC DOI, in conjunction with insurers and ECPs, should re-evaluate the process for network adequacy standards and reporting in 2016 or beyond. Members agreed that though extensive data may not be available to facilitate a comprehensive study of ECP network adequacy, a significant amount of anecdotal data would be available to stakeholders in later years to better inform the assessment of the sufficiency of ECP standards (e.g., provider feedback on patient volume, QHP call center complaints about insufficient access, etc.). Members noted that could potentially allow flexibility to target ECP standards to specific types of services shown to have resulted in ECP shortages.

Points of Consensus

- Workgroup members **reached consensus** to accept the draft workgroup statement regarding the interim establishment of insurer ECP standards, pending the following changes:

  - Modify the first bullet to include "the state will initially require insurers to set network adequacy standards for ECP primary care providers (PCPs, pediatric, and OB/GYN) that are at least equal to what is required for the non-ECP population";
  - Modify the third bullet to read "insurers will be required to meet ECP standards for primary care and report ECP standards for other types of care using the existing state-mandated network adequacy reporting process".
- Workgroup members **reached consensus** that the NC DOI should re-evaluate the ECP network adequacy standards and reporting process within two years of implementation in 2014 to assess whether it has resulted in a sufficient number of ECPs to provide reasonable and timely access for low-income medically underserved individuals in North Carolina.

Next Steps

- The ECP WG will present agreed-upon policy options/workgroup statements to the full NC DOI TAG for consideration.
- Workgroup members are encouraged to send any additional feedback to Allison Garcimonde (agarcimonde@manatt.com) or Lauren Short (lauren.short@ncdoi.gov) of the NC DOI.

FINAL ECP Workgroup Statements

Based on the points of consensus detailed above, the Workgroup's final statements regarding North Carolina's ECP definition, proposed ECP registry process and interim establishment of insurer ECP standards are as follows:

FINAL Workgroup Statement: Defining ECPs in North Carolina

Based on the points of consensus detailed above, the Workgroup's final statement regarding how North Carolina should define ECP follows:

- The State should adopt the expansive federal definition of an ECP at this time, as it does not limit the type of provider included for ECP consideration.
- Per Federal regulations, ECPs are providers meeting the criteria defined in Section 340(b) of the PHS Act or any provider that serves predominantly low-income, medically underserved individuals.
- North Carolina should define "serve predominantly low income, medically underserved individuals" in the following way:
    - Provider organizations whose combined client mix is greater than 50% Medicaid/CHIP, uninsured and/or low-income individuals with incomes at or below 250% FPL.

Workgroup members **reached consensus** to accept as drafted the draft workgroup statement regarding development of an ECP registry process.

FINAL Workgroup Statement: Proposal for ECP Registry Process

Based on the points of consensus detailed above, the Workgroup's final statement regarding a proposed ECP registry process follows:

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

FINAL Workgroup Statement: Interim Establishment of Insurer ECP Standards

- The State will require insurers to set network adequacy standards for ECP providers.
- The State will initially require insurers to set network adequacy standards for ECP primary care providers (PCPs, pediatric, and OB/GYN) that are at least equal to what is required for the non-ECP population.
- 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.

- Insurers will be required to meet ECP standards for primary care and report ECP standards for other types of care using the existing state-mandated network adequacy reporting process.
- To the extent exceptions are permitted under federal law, they will be granted to insurers looking to become QHPs in the North Carolina market.
- The NC DOI should re-evaluate the ECP network adequacy standards and reporting process within two years of implementation in 2014 to assess whether it has resulted in a sufficient number of ECPs to provide reasonable and timely access for low-income medically underserved individuals in North Carolina.