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Vigilance Needed to Make Health Reform Work for 'Essential Community Providers'

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The year 2014 is expected to be momentous in U.S. health policy, as it is when the Affordable Care Act (ACA) is slated to take full effect. With the implementation of the ACA's major expansions in Medicaid and private health insurance, tens of million of previously uninsured Americans could receive affordable coverage. Health insurance coverage should provide numerous health benefits for low-income women and men. It also poses new challenges and opportunities for safety-net providers—including specialized family planning centers—to which uninsured Americans have long turned for care.

To continue serving many of their patients and to survive financially in the face of dwindling grant funding, family planning centers will need to seek out reimbursement from managed care plans and become part of their provider networks. For many family planning centers, that is untrodden ground: In 2010, only 40% had a contract with a health plan to provide contraceptive services to Medicaid enrollees, and only 33% had a contract with a private health plan.[1] Learning to work and contract with health plans will, for many health centers, be a difficult but vital experience (see "Becoming Adept at Working with Health Plans a Necessity for Family Planning Centers," Summer 2012).

In recognition of these challenges and of the unique role that family planning and other safety-net providers play in the lives of their clients, Congress included in the ACA a provision designed to ensure that these providers would not be cropped out of the post–health reform picture: Private plans participating in the upcoming health insurance exchanges will be required to contract with "essential community providers." However, Congress left unanswered important questions about how that term will be defined, what standards plans will have to follow and how safety-net providers will be protected from discrimination.

Origins of the Concept

The term "essential community provider" dates back at least 20 years, to the unsuccessful attempt at health reform under President Clinton.[2] The Health Security Act of 1993 was designed to achieve near-universal insurance coverage, including for millions of low-income women and men who—in the absence of affordable coverage—depended on free or subsidized care through safety-net providers. Although some newly insured people could be expected to turn to private physicians, many others might face difficulties identifying physicians willing and able to take them on as patients, or they might prefer to stick with the providers they know and trust for quality care. The proposal, therefore, included language giving any willing essential community provider (ECP)—a group that would have included Title X family planning providers, federally qualified health centers (FQHCs) and Ryan White HIV/AIDS medical care providers, among others—the option of joining any private health plan's provider network. Alternatively, ECPs could have chosen to be reimbursed as out-of-network providers.

The Clinton health reform plan failed in Congress, but many of its components shaped

subsequent federal and state policies. Notably, managed care plans rapidly gained importance in the private insurance market and in Medicaid in the 1990s. These plans controlled health care costs in large part through their contracts with networks of health care providers; that arrangement could endanger patients' access to safety-net providers, if those providers were shut out of the plans' networks. In the years following the Clinton plan's demise, about a half dozen states adopted policies requiring certain private-market or Medicaid managed care plans to contract with ECPs.

Minnesota, for example, requires health plans to offer contracts to all state-designated ECPs in their service areas. For their part, ECPs must agree—with or without a contract—to serve enrollees of all health plans in their area. Colorado has a similar requirement that applies to managed care plans participating in Medicaid and the Children's Health Insurance Program (CHIP). All such plans must seek proposals from all ECPs in their service area to become part of their provider network and must negotiate with ECPs in good faith. Both states maintain publicly accessible databases of designated ECPs, which must apply for that status. To qualify, family planning centers and many other types of providers must charge clients on a sliding fee scale and serve all patients regardless of income.

Enter the Affordable Care Act

When Congress revisited health reform in 2009, it again turned to a framework that relied on private health plans. Under the ACA, millions of individuals and small businesses will purchase plans from private insurers through state-level insurance marketplaces called "exchanges"; those plans will begin in January 2014. To be certified for an exchange, a health plan must meet numerous regulatory standards, including standards about the adequacy of its provider network. In addition, it must include within its network "essential community providers, where available, that serve predominately low-income, medically-underserved individuals." Specifically, the provision refers to health care providers defined in two preexisting sections of federal law: One of those sections refers to providers qualifying for the 340B drug discount program, a list that includes FQHCs, Title X recipients and many other safety-net health centers and hospitals. The other section of law refers to groups that provide "the same type of services to the same type of populations," but do not receive the grant funding needed to qualify for 340B.

That statutory language left much open to interpretation. In regulations finalized in March 2012, the U.S. Department of Health and Human Services (DHHS) provided some additional clarity, but left considerable flexibility for states and exchanges. Notably, the final regulations provide additional detail in defining the term "essential community provider": It encompasses all providers that fit under the two categories described in the statute, including those that meet the criteria currently and those that met the criteria on the date of the regulations' publication. In the preamble to the regulations, DHHS emphasized that this definition provides a floor and that exchanges could expand the definition to include additional providers. In March 2013, DHHS unveiled a non-exhaustive online database of providers meeting its regulatory definition of an ECP, as a tool for health plans.[3]

The regulations provided less clarity about what standards health plans must follow in contracting with ECPs. Numerous advocacy groups asked for strict standards, such as requiring plans to contract with all willing ECPs or setting specific numerical benchmarks related to enrollees' access to care. DHHS, however, essentially rejected that approach in favor of flexibility for exchanges and health plans: Plans "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." (The regulations also include an alternate standard for plans that employ their physicians directly or contract with a single provider group—arrangements that do not mesh easily with the ECP requirement.) The regulations' preamble emphasizes that exchanges may set more stringent standards.

DHHS did agree with safety-net advocates who asked that ECPs be afforded protections against discrimination by states, exchanges or health

plans. Reproductive health advocates, for example, worried that health centers providing abortion services or referrals, or family planning providers more broadly, might be barred from inclusion in provider networks or otherwise targeted by conservative policymakers, as they have recently in many other contexts (see "Besieged Family Planning Network Plays Pivotal Role," Winter 2013). Under the final regulations, health plans in an exchange "may not be prohibited from contracting with any essential community provider." Moreover, the preamble asserts that health plans "should not discriminate against essential community providers through contract negotiations, or…by offering unfavorable rates"; plans must offer reimbursement rates that are, at a minimum, equal to the rates offered to similar providers.

The regulations do not include specific protections regarding the services to be included in a health plan contract, but DHHS declared that it generally expects plans to contract with ECPs "for all services furnished by the provider that are otherwise covered." For a family planning center, that should include, at a minimum, contraceptive services and supplies and a wide range of other preventive care services provided as part of a patient visit—all of which must be covered by most private health plans under another provision of the ACA (see "Beyond Contraception: The Overlooked Reproductive Health Benefits of Health Reform's Preventive Services Requirement," Fall 2012).

Federally Facilitated Exchanges

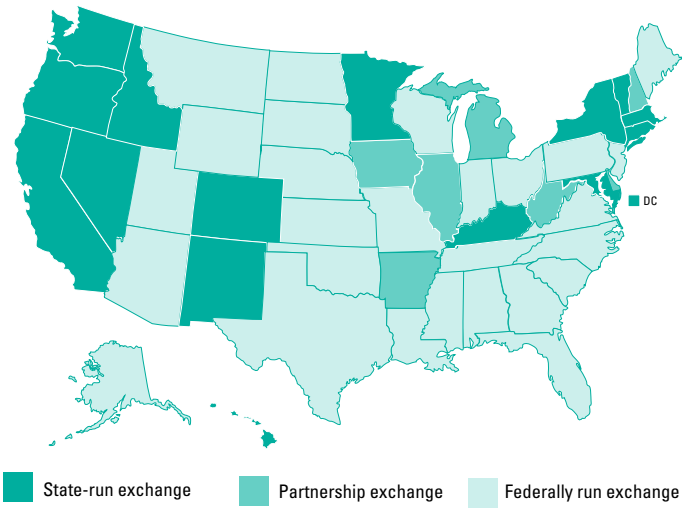
Because the federal regulations provide limited specificity, key decisions about implementing the ECP requirement are left to the exchanges themselves. For the initial year, at least, most exchanges will be run partially or fully by the Centers for Medicare and Medicaid Services (CMS). As of May 2013, 27 states were defaulting to an exchange run entirely by CMS, and another seven states were planning to partner with CMS (see map);[4] many of those decisions might be revisited in subsequent years.

As detailed in a letter to health insurers in April 2013, CMS's approach to certifying health plans for the exchanges relies heavily on existing state regulation and oversight.[5] For example, CMS will rely on states' own network adequacy assessments, whenever possible. Few states, however, had their own versions of an ECP requirement before the ACA was enacted, and so CMS's letter provides a new, explicit standard to answer questions unaddressed by the federal regulations. This standard will apply to the exchanges that CMS runs on its own; for "partnership" exchanges, it will serve as a minimum standard, but states may impose a more stringent one.

The CMS standard—which the agency made clear may be altered after 2014—is far from the "any willing provider" standard promoted by many safety-net advocates. Rather, CMS provides three increasingly lenient options for health plans. The first option is for plans to include in their network at least 20% of the ECPs in their service area, and to offer contracts to at least one ECP in each of six categories in each county, where available. The six categories are FQHCs, family planning providers, Ryan White providers, Indian health care providers, hospitals and a catch-all category that includes such diverse entities as STI clinics, hemophilia treatment centers and black lung clinics.

ESTABLISHING EXCHANGES

As of May 2013, only 16 states and the District of Columbia were planning a state-run exchange for 2014; seven others planned to partner with the federal government, and 27 were defaulting to a federally run exchange, at least for the initial year.



Source: reference 4

For plans that cannot or will not meet that low bar, CMS provides a second option: including in their network only 10% of the ECPs in their service area, without any requirement to promote diversity in specialization or geography. Those plans would merely be required to describe in writing how their networks would provide "an adequate level of service for low-income and medically underserved enrollees."

And even that minimal standard was not the last word. Plans are provided a third option: to not meet even the 10% threshold, but provide justification for how they will "provide access" for these populations of enrollees and how they expect to increase participation by ECPs in future years. In proposed guidance a month earlier, CMS indicated that it would be difficult for health plans to be certified if they relied on this third option, but that language was omitted from the final version, leaving no clear incentive for plans to meet either of the higher standards. As described by Timothy Jost, a health reform expert from the Washington and Lee University School of Law, this change "suggest[s] even greater flexibility on inclusion of ECPs beyond its already remarkably generous policy."[6]

State-Run Exchanges

States that are running their own exchanges could choose to adopt CMS's standard, adopt a different one of their own devising or leave health plans with no clear guidance beyond the federal statute and regulations, instead assessing plans' compliance on a case-by-case basis. The few states that have adopted their own standards provide several contrasting models.

The exchange standards in Minnesota, for example, require that health plans on the exchange—like other health plans the state regulates—be subject to the state's existing ECP standard, which (as described above) requires plans to offer contracts to all ECPs in their service area. According to Ellen Young of Planned Parenthood Minnesota, North Dakota, South Dakota (PPMNS), the state's ECP requirement has been around so long with so little controversy that there was little opposition to applying it to exchange plans.[7] The provision is important for family planning providers in Minnesota; Young reports that PPMNS, for example, has contracts and a good working relationship with all of the state's health plans. For some of the smaller specialized providers, the biggest issue is remembering to renew their ECP status every five years, as required by the state.

In Colorado, the state will use its existing list of designated ECPs in the exchange certification process. Cathy Alderman of Planned Parenthood of the Rocky Mountains reports that this has removed one major question—who qualifies as an ECP—from the list of potential implementation hurdles.[8] However, exchange plans in Colorado will not be subject to the same requirement that Medicaid and CHIP plans face: that they must seek out contract proposals from every ECP in their service area. Rather, an assessment of ECP coverage will be added to the state insurance agency's existing process for assessing a plan's network adequacy, without any specific numerical targets.

The ECP standards adopted in Connecticut are newly designed to apply to plans offered through the state-run exchange. Like those in Minnesota, they are far stronger than those adopted by CMS. Health plans will be required to contract with at least 75% of the ECPs located in each county in the plan's service area, and with at least 90% of FQHCs. If they fall short of those standards, plans will have to demonstrate that they negotiated in good faith, such as by offering contract terms accepted by comparable providers.

California is another state that has adopted explicit new ECP standards for plans offered through its exchange. In many ways, its standards are far closer to CMS's than Connecticut's. Specifically, according to a November 2012 solicitation to insurers, health plans must contract in each county with at least 15% of 340B providers and at least one ECP hospital, and must more generally demonstrate "sufficient geographic distribution" of ECPs. The exchange may require contracts with additional ECPs for lower-income areas. However, the California exchange quietly altered its ECP standard through a public letter in January 2013.[9] The exchange informed health plans that it had removed "single-service

sites"—as opposed to full-services sites such as FQHCs—from the list of 340B providers that would count toward the 15% threshold under its ECP requirement. If that standard holds, it would severely disfavor the numerous safety-net providers that offer focused care, including many family planning centers, STI clinics and Ryan White providers. If these providers are indeed left out, it would go against the clear intent of Congress and could be interpreted as a violation of the federal regulations.

A Role for Advocacy

When it was originally developed in the 1990s under the Clinton reform plan, the ECP concept was designed to ensure that all safety-net providers would have a legitimate chance to survive the health care system's transition to managed care and to continue serving the clients who depend on them. Two decades later, safety-net providers and advocates believed the ACA's provision held the promise to do just that. It is clear that there is serious work ahead if that promise is to be fulfilled, with at least three areas of concern as the ECP requirements begin to take shape state by state.

First is the definition of which providers qualify as ECPs. The federal regulations seem to be strong in this regard, by providing a clear floor that includes, among many others, family planning centers regardless of whether they are part of Title X. The federal database of ECPs should also be helpful in this regard, although some health centers that do not qualify for 340B drug discounts may need to take steps to request that regulators or individual health plans include them on their list. Nevertheless, the move by California's exchange to favor FQHCs over more specialized safety-net providers shows that advocates must be vigilant.

A second key issue is ensuring that family planning providers and other ECPs are protected against discrimination by states, exchanges and health plans. Again, the federal regulations provide a solid starting point, by denying states and exchanges the authority to ban health plans from contracting with any ECPs and by discouraging discrimination by plans in contract negotiations, payment rates and the scope of services covered. Safety-net providers and advocates, along with federal and state regulators, will need to be on the look out for violations of these principles—and push for more explicit protections, if needed.

The third key issue—the standards that health plans must meet to be adequately contracting with ECPs—appears to be the most problematic. For the federally facilitated exchanges, the low regulatory threshold established by CMS—contracting with just 10% or 20% of ECPs in a given area, with few clear requirements for provider diversity—may leave providers specializing in family planning, HIV/AIDS or other STIs ignored in favor of FQHCs and hospitals that provide a broader range of services. These specialized providers, however, are precisely the types that the ECP provision would most benefit: They are indisputably dedicated to disadvantaged and underserved clients, but they may not be fully prepared for contracting with health plans, often depend on scarce and politically vulnerable grant funding, and are all too commonly the subject of ideological attacks.

To address this potential problem, CMS must monitor the impact of the current, modest ECP standards in the exchanges that it runs, as must any state that adopts these or similar standards in running its exchange. If these standards prove inadequate, regulators can turn to the far stronger standards for health plans in Minnesota and Connecticut as models. In state-run exchanges that do not establish any specific numerical targets for health plans to meet, regulators can still strongly enforce the ECP requirement through case-by-case oversight as they review and approve plans. Indeed, state regulators can provide this type of additional enforcement even in states defaulting to a federally facilitated exchange, by focusing on access to ECPs in their oversight of plans' adherence to network adequacy rules. Finally, safety-net providers themselves, in every state, must argue their case to health plans that they belong—and that, in fact, plans should be eager to contract with them to maintain a network that can meet their enrollees' health care needs and meet benchmarks for high-quality care.

There is no shortage of levers available toward achieving the goal of integrating ECPs into America's post-reform health care system. Doing so would help assure that millions of low-income women and men who trust their family planning centers and other safety-net providers can continue to turn to them for the care they need in the decades to come. **www.guttmacher.org**

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