Description and Purpose of Non-Exhaustive HHS List of Essential Community Providers

DESCRIPTION OF THE NON-EXHAUSTIVE HHS LIST OF ECPs:
For the 2016 benefit year, the Centers for Medicare & Medicaid Services (CMS) is releasing an updated list of Essential Community Providers (ECPs) to assist issuers with identifying providers that qualify for inclusion in an issuer's plan network toward satisfaction of the ECP standard under 45 CFR 156.235 for the 2016 benefit year. Under that regulation, ECPs are defined as providers who serve predominantly low-income, medically underserved individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service (PHS) Act and described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act (SSA).

This HHS list contains the following essential community providers:

- Federally Qualified Health Centers (FQHCs) and FQHC look-alikes provided to CMS by the Health Resources and Services Administration (HRSA).
- Ryan White HIV/AIDS Program providers.
- Health centers providing dental services (all of the above organizations that have noted to HRSA that they provide dental services in their scope of project).
- Hospitals: Critical Access Hospitals, Rural Referral Centers, Disproportionate Share (DSH) and DSH-eligible Hospitals, Children's Hospitals, Sole Community Hospitals, Free-standing Cancer Centers.
- STD Clinics, TB Clinics, Hemophilia Treatment Centers, and Black Lung Clinics.
- Rural Health Clinics: A Medicare-certified Rural Health Clinic is included in the non-exhaustive ECP list if it meets the following two requirements: 1) Based on attestation, it accepts patients regardless of ability to pay and offers a sliding fee schedule; or is located in a primary care Health Professional Shortage Area (HPSA) (geographic, population, or automatic[1]); and 2) Accepts patients regardless of coverage source (i.e., Medicare, Medicaid, CHIP, private health insurance, etc.).
- Family planning providers receiving grants under Title X of the PHS Act and not-for-profit or governmental family planning service sites that do not receive a grant under Title X of the PHS Act.
- Indian Health Providers: Tribes, Tribal Organization and Urban Indian Organization providers, and Indian Health Service Facilities.

This HHS list of ECPs is <u>not exhaustive</u> and does not include every provider that participates or is eligible to participate in the 340B drug program, every provider that is described under section 1927(c)(c)(1)(D)(i)(IV) of the SSA, or every provider that might otherwise qualify under the regulatory standard under 45 CFR 156.235. While CMS is providing this updated list for the 2016 benefit year, Qualified Health Plan (QHP) issuers may continue to write-in providers in their QHP application for consideration that meet the regulatory standard but do not appear in the HHS list of ECPs.

[1] As of January 1, 2014, more than 1,000 Rural Health Clinics (RHCs) were designated as an automatic Health Professional Shortage Area (HPSA), the criteria for which include accepting patients regardless of ability to pay; offering a sliding fee schedule based on ability to pay (income); and accepting Medicare, Medicaid, CHIP, and private health insurance patients. To receive the automatic HPSA designation, each RHC is required to complete an attestation form, which is available here: http://bhpr.hrsa.gov/shortage/hpsas/certofeligibility.pdf. RHCs that are not listed on the current non-exhaustive ECP list and complete the attestation form to receive an automatic HPSA designation through the Health Resources and Services Administration will be included in future non-exhaustive ECP lists. More information about the HPSA designation requirements and process is also available here: http://bhpr.hrsa.gov/shortage/hpsas/ruralhealthhpsa.html.

PURPOSE OF HHS LIST OF ECPs:
CMS will use this non-exhaustive HHS list of ECPs, together with any CMS-approved ECPs that a respective issuer may write-in on their QHP application, as the basis for determining the number of available ECPs in the QHP's service area. In other words, the denominator of the percentage of available ECPs included in the issuer's provider network(s) includes ECPs in the QHP's service area that are listed in the HHS list of ECPs, as well as eligible ECPs that a respective issuer lists as ECP write-ins based on ECP write-in criteria provided in the forthcoming 2016 Letter to Issuers.[2] All providers included in a QHP issuer's application that meet the federal regulatory standard will count toward the numerator of the ECP evaluation percentage. Additionally, issuers may use the contacts on the list to aid in provider network development.

IMPROVEMENTS TO HHS LIST OF ECPs BASED ON PUBLIC COMMENTS ON DRAFT LIST:
As a direct result of public comments received on the Draft HHS List of ECPs, CMS has made significant improvements to the accuracy of the provider data on the HHS List of ECPs for benefit year 2016. CMS coordinated closely with HRSA, the Indian Health Service (IHS), and the Office of the Assistant Secretary for Health/Office of Population Affairs (OASH/OPA) to review requested corrections and additions received directly from providers. We were able to verify the majority of these provider requests and have updated the ECP list accordingly. In response to public comments, we will be considering some formatting changes to the ECP list for benefit year 2017 to accommodate additional provider data, such as points of contacts and phone numbers for each ECP type listed in the ECP list.

We also received a number of suggested corrections, additions, and removals from third-party entities that were not ECPs themselves. Among these non-provider commenters were state Departments of Health, state-based provider associations, and issuers. In some cases, we were able to verify the information provided by these non-provider entities to allow us to incorporate the requested change. We made particular efforts to do so when we were informed that a specific provider was no longer in practice. However, we have deferred many of the non-provider requests until direct follow up with the respective provider can take place to confirm the new data, rather than making the change based solely on third-party information.

For the 2016 benefit year, we were unable to accommodate requests to add certain types of providers, such as Community Mental/Behavioral Health Centers, Rural Health Clinics that have not been designated as an automatic HPSA by HRSA, and individual clinicians not currently participating in one of the federal programs that provided our source provider data. Issuers will continue to have the latitude to write-in providers that are not on the list, particularly providers that provide health care to populations residing in low-income zip codes or HPSAs, on the condition that they do not limit their practice on the basis of a particular source of coverage (i.e., Medicare, Medicaid, private health insurance, etc.). In future years, we will be exploring the feasibility of reviewing additional providers for inclusion on the ECP list in accordance with the requirements in 45 CFR 156.235.

CMS intends to make no additional changes to the ECP list for the 2016 benefit year. We will endeavor to continue improving the accuracy of the provider data for future years. These efforts will include outreach to ECPs themselves, as well as reviewing the provider data with our federal partners. We recommend that individual ECPs ensure that their information is up to date with all their federal partners, and that issuers, trade associations, and other third parties refer concerns about individual listings to the respective providers themselves.

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[2] The Draft 2016 Letter to Issuers in the Federally-facilitated Marketplaces is available at: http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html.