750 EAST PRATT STREET, 16TH FLOOR
BALTIMORE, MD 21202
marylandhbe.com

MARYLAND HEALTH BENEFIT EXCHANGE

To: Issuers Participating in Maryland Health Connection
From: Maryland Health Benefit Exchange - Plan Management
Date: January 31, 2016
Re: MHBE – Instruction on Meeting the 2017 Essential Community Provider Plan Certification Standard

---

This document provides the operational method issuers participating in Maryland Health Connection must follow in order to meet the 2017 Essential Community Provider (ECP) Plan Certification Standard released in the Final 2017 Letter to Issuers. The MHBE approach matches that of the FFM with certain specific differences:

1. **Expanded Essential Community Provider Definition**: MHBE has expanded the definition of ECP to include, in addition to the definition established under 45 CFR § 156.235(c), a local health department, an outpatient mental health center or substance use disorder treatment provider (as described at COMAR 10.09.80.03.B(1) & B(3)) that is licensed or approved by DHMH as a program or facility, or a school-based health center. Hereafter, the new ECP's described in the expanded definition will be termed "2016 Expansion Providers." Further, 2016 Expansion Providers must meet issuer credentialing standards.

2. **ECP Network Inclusion Standards**: To be certified, issuer QHP networks must meet certain ECP Network Inclusion Standards

a. The issuer must contract with at least 30% of available ECPs in each plan's service area as part of each plan's provider network. MHBE will allow a write-in option and an alternative standard for issuers to meet this requirement.
b. Issuers must offer contracts in good faith to the following provider types:
   - all available Indian Health Care Providers in service area
   - any willing local health department in the plan's service area, and
   - at least one ECP in each ECP category in each county in the issuer's service area, where an ECP in that category is available and provides medical or dental services by issuer plan type (i.e., geographic inclusion standard)

   2016 Expansion Providers are included in the total ECP population for the purposes of reaching the 30% contract network inclusion standard. 2016 Expansion Providers are considered an additional ECP category. To provide clarification, issuers are expected to offer contracts, in good faith, to at least one 2016 Expansion Provider, in addition to at least one provider in each of the other ECP categories, in each county in the issuer's service area.

750 EAST PRATT STREET, 16TH FLOOR
BALTIMORE, MD 21202
marylandhbe.com

MARYLAND HEALTH BENEFIT EXCHANGE

3. **Combined HHS and MHBE List of ECPs**: MHBE will provide to issuers a non-exhaustive list, in Excel format, of available ECP's based on data maintained by DHMH that is supplemented with a list of ECP's (so indicated) based on data maintained by CMS and other federal agencies. The expansion ECP's are denoted in the list with a binary "Yes/No" indicator in column M. This column is labeled "ECP Type: 2016 Expansion Providers." ECP data that is provided from DHMH is indicated in column N with a binary "Yes/No."

   Issuers should use this list to identify providers that MHBE and DHMH consider ECPs. While the 2016 Expansion Providers are exclusive to the DHMH list, the list also includes providers that span across the traditional ECP categories. Provider NPIs have been included when provided by DHMH. Provider NPIs have been supplemented with the Organization EIN number from the HHS list. MHBE and DHMH will update the Combined ECP List on a quarterly basis to ensure the most up-to-date list of ECPs. Issuers should report list discrepancies or inaccuracies to MHBE.

   The total ECP list includes 872 providers, 816 of which are included in the DHMH List, 691 of which have a listed NPI.

4. **MHBE ECP Denominator Methodology:** MHBE will count individual providers located at one physical location each as a provider for the denominator. Issuers may elect one of two different methodologies to meet the ECP Network Inclusion standard:

   A. DHMH-list denominator: Using this method MHBE will use the list of applicable (i.e., within an issuer's service area) providers with the DHMH indicator (column M), and any allowable ECP write-ins (see Write-in Option) as an issuer's denominator for evaluating compliance with the contracted-ECP network inclusion standard. MHBE is confident that the ECPs on the provided DHMH list will meet issuer credentialing standards. This is the default denominator method.

      As an example, under this methodology a statewide provider network must contract with at least 242 ECPs (i.e. 30% of the total 808 ECP pool) to meet the 30% network inclusion standard. To assist issuers, MHBE has created a table (see Table 4-1) that displays the number of ECPs in a given provider category, the number of ECPs on the DHMH-list, and the number of providers with listed NPIs. These data are stratified by county.

      The denominator for this method is determined through the summation of the number of DHMH ECPs for each county within an issuer's service area. Issuers should use Table 4-1 to determine their denominators.

750 EAST PRATT STREET, 16TH FLOOR
BALTIMORE, MD 21202
marylandhbe.com

MARYLAND HEALTH BENEFIT EXCHANGE

B. Credentialing-standard adjusted denominator: In cases where issuers determine they are/will be unable to contract with a significant number of ECPs, such that they will be unable to meet the network inclusion standard using the DHMH list denominator, they may elect to use an adjusted denominator. The issuers must show that their differences in credentialing standards would adversely affect (ECP credentialing standards/contracts are subject to MHBE review) issuer network quality if they contracted with the ECP. Allowable ECP write-ins will also apply to the adjusted denominator.

   Issuers opting to use this methodology would be able to adjust their ECP network inclusion denominators with an attestation to MHBE that certain ECPs do not meet their credentialing standards. Issuers opting to use this methodology must, along with the ECP MHBE IDs, submit their ECP credentialing standards/contracts and clearly identify the contract standards the ECPs did not meet (this data should be aggregated and summarized for the ECPs that did not meet credentialing standards, for example "quality" or "billing limitations"). Upon approval, the MHBE IDs will be removed from the total eligible ECP pool and the issuer's denominator for meeting the network inclusion standard will be adjusted accordingly. A signed PDF of the attestation and an Excel spreadsheet with the ECP MHBE IDs/summarized credentialing information would be sufficient.

   Issuers will have until May 1, 2016 to opt into this methodology by notifying MHBE of their intent. Issuers will have until June 1, 2016 to submit their attestation and ECP MHBE IDs. MHBE will respond to the issuer within three (3) business days with the issuer's new denominator and benchmarks, if approved.

   For example, using the adjusted denominator method, if an issuer with a statewide network submits 120 ECPs that did not meet their credentialing standards, upon approval, MHBE would subtract the 120 ECPs from the DHMH-list denominator of 816. This would reduce the issuer's denominator to 696 ECPs and the 30% inclusion standard to 209 providers.

5. **Submission of the Issuer Contracted ECP List & Write-in Option:** Issuers will use the CCIIO-developed Essential Community Provider Template to report to MHBE which ECPs they have contracted for their networks. Issuers will identify 2016 Expansion Providers through selecting "NA" in column D, "ECP Category," for each contracted expansion provider. In order to validate the template issuers will also have to fill in the appropriate "Provider Type" in column C.

Table 4-1. Essential Community Providers by County and Category.

Essential Community Providers by County and Category

Note:Categorization counts are not mutually exclusive, the count for providers in each category incldues providers only on the DHMH list.

Site County	ECP Type: Hospital	ECP Type: FQHC	ECP Type: Ryan White	ECP Type: Family Planning	ECP Type: Indian Provider	ECP Type: Other	ECP Type: 2016 Expansion Providers	Providers with NPIs	DHMH ECP List	List w/ HHS Supplement
Allegany	1	2	0	1	0	0	14	14	17	18
Anne Arundel	0	3	0	1	0	2	37	38	41	43
Baltimore	1	5	0	10	0	0	76	77	85	88
Baltimore City	11	38	9	13	0	3	147	155	192	209
Calvert	0	0	0	0	0	1	12	12	12	13
Caroline	0	13	0	5	0	3	31	31	35	37
Carroll	0	0	0	0	0	0	0	0	0	0
Cecil	0	2	0	2	0	2	10	11	12	12
Charles	0	1	0	5	0	4	13	13	15	15
Dorchester	0	2	0	2	0	2	16	17	17	21
Frederick	0	0	0	1	0	0	21	21	22	24
Garrett	1	1	0	6	0	4	4	5	8	8
Harford	0	4	0	1	0	1	25	25	28	29
Howard	0	1	0	3	0	3	14	14	15	17
Kent	0	0	0	2	0	2	5	5	5	6
Montgomery	3	9	0	6	0	0	60	64	77	81
OOS	0	33	0	1	0	0	4	16	37	42
Prince George's	1	7	4	10	0	2	68	69	82	85
Queen Anne's	0	0	0	2	0	1	12	11	12	13
Somerset	0	2	0	2	0	2	7	7	8	9
St. Mary's	1	0	0	1	0	1	13	13	14	15
Talbot	0	6	0	4	0	1	15	15	17	19
Washington	0	5	0	3	0	3	25	27	28	29
Washington DC	0	2	0	0	0	0	0	1	2	2
Wicomico	0	7	0	2	0	4	20	21	27	27
Worcester	0	1	0	4	0	2	9	9	10	10
State-Wide	19	144	13	87	0	43	658	691	818	872

750 EAST PRATT STREET, 16TH FLOOR
BALTIMORE, MD 21202
marylandhbe.com

MARYLAND HEALTHBENEFIT EXCHANGE

Additionally, issuers will be allowed to submit ECPs through a Write-in Option. The following information is required for Write-in Option ECPs:

- provider's zip code reflecting provider location within a low-income zip code or Health Professional Shortage Area included on the "Low-income and Health Professional Shortage Area Zip Code Listing" located at: http://www.cms.gov/cciio/programs-and- initiatives/health-insurance-marketplaces/qhp.html
- The provider's street address (P.O. Box is not sufficient)
- The National Provider Identifier (NPI) number, if the provider has an NPI number.

For the purposes of filling out the ECP Template, issuers must denote each Write-in ECP through filling in "No" in column J, "On ECP List," for each Write-in provider. Issuers that contract with the supplementary HHS ECPs that are not included on the DHMH provider list, i.e. indicated as "No" in column N, must identify these ECPs as Write-ins.

6. **MHBE ECP Network Inclusion Calculation Methodology:** MHBE will use the equation below to determine whether issuers meet their ECP network inclusion standards:

For the DHMH-list denominator method:

$$Issuer_1\ Network_A(\%) = \frac{Number\ of\ contracted\ ECPs + \text{"Write in" } ECPs}{Total\ N\ of\ ECPs\ in\ Network_A\ Service\ Area + \text{"Write in" } ECPs} \times 100$$

For the Credentialing-standard adjusted denominator:

$$Issuer_2 Network_A(\%) = \frac{Number\ of\ contract\ ECPs + \text{"Write in "} ECPs}{(Total\ N\ of\ ECPs\ in\ Network_A\ Service\ Area - Adjustment\ ECPs) + \text{"Write in" ECPs}} \times 100$$

MHBE will count individual providers located at one physical location each as a provider for the denominator.

7. **MHBE ECP Geographic Inclusion Calculation Methodology:** MHBE Plan Management will determine if issuers meet the geographic inclusion standard through the Contracted ECP List submission. Additionally, issuers must self-report the counties without a single ECP in each category and submit the MHBE IDs of the ECPs outreached to in good faith. Issuers must submit this information when they

750 EAST PRATT STREET, 16TH FLOOR
BALTIMORE, MD 21202
marylandhbe.com

MARYLAND HEALTHBENEFIT EXCHANGE

submit their Contracted ECP List. In such cases where MHBE identifies a county that does not meet the geographic ECP standard for a given issuer, the issuer must submit the same information requested in the self-report. Issuers should submit this information to MHBE within 3-5 business days. MHBE will use this information to verify an issuer's attempted good-faith effort to meeting the geographic standard.

8. **Alternative ECP Standards when General ECP Standards are Unmet:** If an issuer cannot meet the general ECP standard, the issuer will be required to include, as part of its submission, a satisfactory narrative justification, i.e. the alternative ECP standard. Issuers must demonstrate through this narrative that low-income members receive appropriate access to care and satisfactory service. The narrative explanation should describe the extent to which the issuer's provider sites are accessible to, and have services that meet the needs of, specific underserved populations, including:

    a. Individuals with HIV/AIDS (including those with comorbid behavioral health conditions);
    b. American Indians and Alaska Natives (AI/AN);
    c. Low-income and underserved individuals seeking women's health and reproductive health services; and
    d. Other specific populations served by ECPs in their service area.

    Issuers submitting a narrative justification must submit to MHBE provider quality and patient satisfaction metrics:

    - Current year and previous year issuer performance on the CAHPS including all CAHPS Composites against the 90th Percentile National Benchmark;
    - Accreditation scores for each Element (using the 2016 Standards and Guidelines for the Accreditation of Health Plans) of the "QI 5: Complex Case Management" and "QI 6: Disease Management" Standards for Quality Management and Improvement; MHBE will also require information on which factors within the Elements an issuer has met;
    - Current year and previous year issuer complaint data on Quality of Care, Access, Attitude/Service, Billing/Financial, Quality of Practitioner Office Site, Total Average Complaints per 1000 members; issuers must also provide performance goal of complaints per 1000 members.

    These metrics may be submitted within the issuer's narrative but may also be attached to the submission as an Excel worksheet.

750 EAST PRATT STREET, 16TH FLOOR
BALTIMORE, MD 21202
marylandhbe.com

MARYLAND HEALTHBENEFIT EXCHANGE

9. **Submission of ECP Standards + ECP-related Documentation:** Issuers should submit all ECP-related templates and documentation into their SERFF Binders for processing by MHBE Plan Management.

Table 9-1. Required Document Submission Timeline

Document	Submission Date	Submission Method	Format
Intent to use Adjusted Denominator Methodology	May 1, 2016	mhbe.issuers@maryland.gov	Signed PDF
Adjusted Denominator Attestation and MHBE IDs	June 1, 2016	SERFF Binder	Signed PDF + Excel Spreadsheet
Essential Community Provider Template	July 1, 2016	SERFF Binder	CCIIO Template
Geographic Inclusion Supplement	July 1, 2016	SERFF Binder	Excel Spreadsheet
Alternative ECP Standard Narrative	July 1, 2016	SERFF Binder	PDF + Excel Spreadsheet

10. **Notice of ECP Standard Approval:** MHBE will notify issuers of their performance against the network inclusion and geographic standards within five (5) business days of submission of their Essential Community Provider Templates on July 1, 2016. Issuers that do not meet these standards and have not submitted the appropriate documentation should work to submit the information within five (5) business days after receiving notice.

11. **Dental ECP Inclusion Standard:** MHBE will follow the FFM approach for evaluation of ECP Network Inclusion for SADPs. SADPs will be considered compliant with the ECP standard if, in their application, they offer a contract in good faith to at least 30% of available ECPs in each plan's service area to participate in the plan's provider network and offer a contract in good faith to all available Indian Health Care Providers in the plan's service area. MHBE considers the ECP category per county service area requirement not applicable to SADPs, but strongly encourages SADP issuers to contract with at least one FQHC and any willing LHDs. MHBE will work with stakeholders to determine if an ECP category per county service area requirement should be imposed in future plan years.

    There is no expansion with respect to Dental ECPs. The list of ECPs includes those applicable to Stand-Alone Dental Plans on the second tab.

750 EAST PRATT STREET, 16TH FLOOR
BALTIMORE, MD 21202
marylandhbe.com

MARYLAND HEALTH BENEFIT EXCHANGE

Frequently Asked Questions

1. **The proposed standard indicates that issuers must offer contracts in "good faith" to qualifying providers. What are some of the tenets of good faith as you have proposed it? Does it require anything of plans in regards to reimbursement rates?**

   MHBE will follow the FFM standard for this definition: "To be offered in good faith, an issuer should offer contract terms comparable to terms that it offers to a similarly-situated non-ECP provider. CMS expects issuers to be able to provide verification of such offers if CMS requests to verify compliance with the policy." Contract terms may include reimbursement rates.

   Further, MHBE encourages issuers to use objective, transparent and Parity Act-compliant standards. Issuers are encouraged to ensure that credentialing requirements do not effectively exclude a type of ECP. MHBE will revisit this requirement if future experience shows that credentialing requirements do exclude a type of ECP.

2. **What are the effective "service areas" as outlined in the standard? It seems to mean the entirety of the area where the plan is purchasable, but the standard also sets minimums by county, is that correct?**

   MHBE approaches ECPs and service areas in two contexts:

   1. Contracts with at least 30 percent of available ECPs in each plan's service area to participate in the plan's provider network;
   2. Offers contracts in good faith to at least one ECP in each ECP category (see Table 4-H-1) in each county in the service area, where an ECP in that category is available and provides medical or dental services that are covered by the issuer plan type.

   For item 1, 30% of ECPs within their service area is setting a floor with respect to volume of providers over the span of their entire service area. For item 2, setting a floor with respect to geographic access.

   With only the first standard in place a state-wide HMO would be able to meet their ECP standard by contracting with all of the ECPs in major population centers, restricting rural members from access to an ECP. With the second standard in place, that state-wide HMO must meet a minimum level of access to an ECP anywhere in the state - thereby expanding a minimum level of access to rural members. This two-

750 EAST PRATT STREET, 16TH FLOOR
BALTIMORE, MD 21202
marylandhbe.com

MARYLAND HEALTHBENEFIT EXCHANGE

pronged approach answers the access question through addressing volume and geographic concerns.

3. **"Plans must offer contracts in good faith to at least 1 ECP in each ECP category in each county in the service area, where an ECP in that category is available and provides medical or dental services by issuer plan type". What are the ECP categories here, are they borrowed from the non-exhaustive CMS list categories? Are behavioral health providers included here or purposefully excluded?**

See the below table from the MHBE Final 2017 Letter to Issuers:

Table 4-H-1. ECP Categories

ECP Category	ECP Provider Types Included in Category
Family Planning Providers	Title X Family Planning Clinics and Title X "Look-Alike" Family Planning Clinics
Federally Qualified Health Centers (FQHC)	FQHC and FQHC "Look-Alike" Clinics, Outpatient health programs/facilities operated by Indian tribes, tribal organizations, programs operated by Urban Indian Organizations
Hospitals	Disproportionate Share Hospital (DSH) and DSH-eligible Hospitals, Children's Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals
Indian Health Care Providers	Indian Health Service (IHS providers), Indian Tribes, Tribal organizations, and urban Indian Organizations
Ryan White Providers	Ryan White HIV/AIDS Program Providers
Other ECP Providers	STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, Community Mental Health Centers, Rural Health Clinics, and other entities that serve predominantly low-income, medically underserved individuals.
2016 Expansion Providers	Local health departments, outpatient mental health centers, and substance use disorder treatment providers, as described at COMAR 10.09.80.03.B(1) & B(3), licensed or approved by DHMH as programs or facilities, and school-based health centers

750 EAST PRATT STREET, 16TH FLOOR
BALTIMORE, MD 21202
marylandhbe.com

MARYLAND HEALTH BENEFIT EXCHANGE

4. **How will MHBE measure compliance with the "Contract with at least 30%of available ECPs in each plan's service area" standard? Are sites or organizations the operative unit of measure? For clarification, will contracting with a provider organization with multiple sites in a service area be the same as contracting with provider with a single site?**

   MHBE will provide a modified version of the FFM template to capture the ECPs the issuer contracts with by ECP type and location. MHBE will count individual providers operating at a single site. FFM will be moving to this counting methodology in 2018.

5. **Currently, there is no comprehensive inventory of services provided by LHDs and SBHCs. FQHC services may differ across site and will be staffing dependent. Can QHPs contract for a limited set of services/limited sites with an ECP? How will a contract for limited services be treated under the 30% standard?**

   Like CMS, MHBE generally anticipates and expects QHP issuers will contract with essential community providers for all services furnished by the provider that are otherwise covered by the QHP.

6. **LHDs and FQHCs frequently sponsor SBHCs and LHDs and may contract with provider(s) to provide health services. How will these relationships be governed under the proposed standard? Can the organizations in the expanded standard (LHDs, SBHCs) subcontract for health services? Are the providers with whom they contract ECPs for the purpose of the standard?**

   Similar to the FFM, MHBE has placed no restrictions or requirements around on subcontracts. We would count, and will include this additional detail in the ECP templates, a provider as an ECP if they provide the services - regardless of whether they are subcontracted out. Such centers allow subcontracting to meet their care provision goals, MHBE sees no problem with such an approach.

These FAQs will be updated. Issuers may submit questions to mhbe.carriers@maryland.gov.