ACCESS TO HEALTH CARE AND THE AFFORDABLE CARE ACT:

Investigating the Potential of Essential Community Provider and Network Adequacy Legislation to Improve Access to Healthcare for Underserved Populations in California

BY: MAJNA DUKIC, BO ESPINOSA-SETCHKO, KATJA NELSON, HUIXIN ZHENG
ACKNOWLEDGMENTS

We would like to extend our sincerest thanks to our advisor, Aaron Panofsky, for his constant support and guidance on this journey. His excellent coaching and patience was an integral part of the process.

We would also like to thank the following UCLA faculty members for helping us understand the health policy landscape and politics of healthcare delivery in California: Arturo Vargas-Bustamante, Arleen Leibowitz, Dylan Roby, Mark Peterson, Wes Yin, Sarah Reber, and Mark Kleiman. We would especially like to thank Jesse Martin, one of our colleagues, who gave us a “crash course” on Covered California and the Health Benefit Exchange website.

Finally, our project would not have been possible without the help of key representatives from the regulatory and health policy world, including Nancy Pheng Street, Nancy Samra, Isaac Menashe, Ahmed Al-Dulaimi, Alison Mangiaracino, Laurie Sobel, Alina Salgonicoff, Shelley Rouillard, Richard Figueroa, Rachel Tobey, Teri Boughton, and Beth Malinowski.

“This report was prepared in partial fulfillment of the requirements for the Master in Public Policy degree in the Department of Public Policy at the University of California, Los Angeles. It was prepared at the direction of the Department and of Dr. Richard Baker as a policy client. The views expressed herein are those of the authors and not necessarily those of the Department, the UCLA Luskin School of Public Affairs, UCLA as a whole, or the client.”
# Table of Contents

List of Terms .................................................................................................................. 6

Executive Summary ......................................................................................................... 8

Chapter 1: Introduction to Network Adequacy and Essential Community Providers .......................... 10
  Background on the Affordable Care Act (ACA) .......................................................... 10
  Background on Network Adequacy ............................................................................. 12
  Background on Essential Community Providers ....................................................... 13
  Background on Target Population ............................................................................. 14
  Our Client ................................................................................................................... 15

Chapter 2: Understanding Healthcare Access and Disparities .............................................. 16
  What are Health and Healthcare Disparities? ............................................................ 16
    Health Disparities ....................................................................................................... 16
    Healthcare Disparities .............................................................................................. 17
  How is Access to Healthcare Defined? ...................................................................... 17
  What are some of the Barriers to Health Care Access? ............................................. 18

Chapter 3: Policy Questions ............................................................................................. 19
  Policy Questions .......................................................................................................... 19
    Why are the Network Adequacy and Essential Community Provider Standards failing to close the gap in securing adequate access to care for underserved populations in California, and should policy be optimized or revised to close the gap? .............................................. 19

Chapter 4: Methodology .................................................................................................. 21
  Literature Review ........................................................................................................ 21
  Key Informant Interviews ......................................................................................... 21
  Quantitative Data Gathering and Processing ........................................................... 22

Chapter 5: Are the Network Adequacy and Essential Community Providers Regulations Effective? ........................................................................................................ 23
  Category 1. Are the Network Adequacy Regulations Effective? ............................... 23
    Methods of evaluation .............................................................................................. 23
    How is Network Adequacy regulated? .................................................................... 23
    Is the Network Adequacy Standard Enforced? ......................................................... 26
  Category 2: Is the Essential Community Provider Regulation Effective? ................ 27
    Method of Evaluation ............................................................................................... 27
    How is the ECP Standard Regulated? ................................................................... 28
    What are the differences between the federal and state based definitions of ECPs? ...................................................................................................................... 30
  Is the Essential Community Provider Standard Effective? ..................................... 31

CONCLUSION .................................................................................................................... 35
Chapter 6: The Effect of Provider Supply On Network Adequacy and the Essential Community Provider Standard

The Worsening Primary Care Physician Supply Shortage .................................................. 36
Health Professional Shortage Areas .................................................................................. 37
Healthcare Deserts .......................................................................................................... 40
South Los Angeles and Service Planning Area 6 .............................................................. 42

Chapter 7: Potential Areas of Optimization within the ECP and Network Adequacy Legislation

Area of Optimization: Regulatory Oversight of Network Adequacy ................................ 47
  Is it feasible? .................................................................................................................. 47
  What are the benefits and tradeoffs? ........................................................................... 48
  Will improved regulation of Network Adequacy result in improved access to healthcare for low-income medically underserved patients? ................................................. 49

Area of Optimization: Legal Language of Network Adequacy ...................................... 50
  Is it feasible? .................................................................................................................. 50
  What are the benefits and tradeoffs? ........................................................................... 50
  Will improving the legal language of the Network Adequacy standard result in improved access to healthcare for low-income medically underserved patients? .......................... 51

Area of Optimization: Metrics of Network Adequacy ..................................................... 51
  What is the MSSA metric? ........................................................................................... 51
  Is it feasible to use MSSAs as the service area metric for Network Adequacy? ............. 52
  What are the benefits and tradeoffs of using MSSAs? ................................................. 53
  Would using MSSAs help improve access to care? ..................................................... 53

Area of Optimization: Improved Regulatory Oversight of ECP ....................................... 54
  Is it feasible? .................................................................................................................. 54
  What are the benefits and tradeoffs? ........................................................................... 55
  Will Better Regulating the ECP Standard result in improved access to care for low-income medically underserved populations? ......................................................... 55

Area of Optimization: Legal Language of Essential Community Provider Standards .... 57
  Is it feasible? .................................................................................................................. 57
  What are the benefits and tradeoffs? ........................................................................... 57
  Will better regulating the ECP Standard result in improved access to healthcare for low-income medically underserved patients? ......................................................... 58

Area of Optimization: Metrics of Essential Community Provider Standards ............... 59
  Is it feasible? .................................................................................................................. 59
  What are benefits and tradeoffs? .................................................................................. 60
  Will using MSSAs as the service area for the ECP standard help increase access to care for low-income medically underserved populations? .................................................. 61

Area of Optimization: Provider Expansion within Essential Community Provider Standards ...... 61
  Is it feasible? .................................................................................................................. 61
  What are the benefits and tradeoffs? ........................................................................... 62
Will Including More Types of Providers in the ECP Definition Improve Access to Care? .................. 62

Chapter 8: Recommendations & Conclusions ................................................................. 64
Recommendations ........................................................................................................... 64
Limitations ....................................................................................................................... 66
Further Research .............................................................................................................. 67
Conclusion ....................................................................................................................... 68

Appendices ...................................................................................................................... I
Appendix B: Qualified Health Plan Metal Tiers .............................................................. II
Appendix C: Description of Key Informants .................................................................. III
Appendix D: Sample Interview Questions ..................................................................... V
Appendix E: Data Set Descriptions and Data Abstraction Tools ........................................ VII
Appendix F: Essential Community Provider Standard: Federal vs. California Exchange ...... VIII
Appendix G: Stata Log for Dropping Duplicates on the Covered California Non-Exhaustive List of Essential Community Providers ................................................................. IX
Appendix H: Legal Text for Network Adequacy and Essential Community Provider Standards within Title 45, the Public Welfare Section of the Code of Federal Regulations ................. X

“§156.230 Network adequacy standards ........................................................................ Y
“§156.235 Essential community providers .................................................................. Y

-Page 5 of 84-
LIST OF TERMS

ACA - Affordable Care Act

CHHS: California Health and Human Services Agency

CMS: Centers for Medicare & Medicaid Services

Covered California: California’s Health Benefit Exchange, through which Qualified Health Plans are sold.

CDU: Charles Drew University

DMHC: Department of Managed Health Care

DHCS: Department of Health Care Services

DOI: California Department of Insurance

ECP: Essential Community Provider

EPO: Exclusive Provider Organization

FPL: Federal Poverty Level

HBE: Health Benefit Exchange

HHS: Health and Human Services

HPSA: Health Provider Shortage Area

HRSA: Health Resources & Services Administration

HMO: Health Maintenance Organization

LIMU: Low-Income Medically Underserved Populations

MSSA: Medical Service Study Area

Network Adequacy- a health insurance plan’s capacity to meet patients’ needs through acceptable access to an adequate number of in-network primary care providers, specialty care providers, and all other health services outlined within their contract.

OSHPD: Office of Statewide Health Planning and Development
POS: Point of Service

PPO: Preferred Provider Organization

Provider Network: The individual physicians, clinics, and hospitals included in an individual’s health plan network.

QHP: Qualified Health Plan

SBE: State Based Exchange

SPA: Service Planning Area
**EXECUTIVE SUMMARY**

Dr. Richard Baker of Charles Drew Medical University (CDU) commissioned our research team to provide recommendations for optimizing the Network Adequacy and Essential Community Provider standards to better address the health care access needs of low-income, medically underserved (LIMU) populations in California. In spite of continued efforts to increase access to health care, health disparities persist in disease incidence rates, treatment rates, and the burden of disease, suggesting that either legislation is not being optimized, or legislation is not the answer. Qualified Health Plans (QHPs) sold on the newly created Health Benefit Exchange (HBE) are required to include a certain number of safety net providers, known as “Essential Community Providers” (ECPs). The current state and national efforts to eliminate these disparities along with the health insurance expansion through the Affordable Care Act open up a serendipitous window of opportunity to better optimize Network Adequacy and Essential Community Provider (ECP) legislation. Dr. Baker would like to see these standards optimized by including solo-practice providers, and by employing metrics that better match the geographic distributions of health care disparities. This assertion is based on an assumption that optimizing the legislation will improve access to health care for low-income medically underserved populations in California.

To evaluate the potential of Dr. Baker’s proposed solution, our research team first had to consider the merit of an assumption that the legislation had the potential, when optimized, to reach the stated goal, and to evaluate the extent to which the existing legislation in practice was binding for insurance companies and regulatory efforts were effective. To answer these questions, our research consisted of a thorough literature review, interviews with key stakeholders, and public data set analysis to understand inefficiencies in the system.
Initial quantitative and qualitative data analysis provided minimal evidence that even when optimized to meet regulatory standards through data cleanup, expansion, and enforcement, the ECP provision will close the gap for health care access needs for the most vulnerable populations on the exchange in the setting of a supply shortage.

Therefore, in the short-term, our recommendations for legislative optimization include directing efforts toward (1) robust regulatory oversight, (2) improved legislative text, and (3) consistent metrics for the ECP provision to improve network adequacy for patients on the Health Benefits Exchange. However, these short-term solutions will not be a silver bullet to resolve health care access needs for low-income, medically underserved populations in California. We propose that a potential direction for Dr. Baker is to advocate to increase the supply of providers in California as a first step in improving access to care for low-income medically underserved populations, and potentially only after this is achieved can legislation be truly optimized to help close the access gap.
Chapter 1: Introduction to Network Adequacy and Essential Community Providers

“I mean, everybody should have access to medical care. And, you know, it shouldn't be such a big deal.” - Paul Farmer, American Physician, Co-founder of Partners in Health.ii

The problem is, it is a “big deal”. In particular, it has been incredibly difficult to translate the Network Adequacy and Essential Community Provider (ECP) standards into increased access to healthcare for low-income, medically underserved populations, and our client, Dr. Richard Baker, has charged us with understanding the primary challenges to achieving success.

While both the Network Adequacy and Essential Community Provider standards have the potential to increase health care, our group investigated the extent to which optimization of each standard could improve health care access. Our policy question as we began our investigation was as follows: Why are the Network Adequacy and Essential Community Provider Standards failing to close the gap in securing adequate access to care for underserved populations in California, and should policy be optimized or revised to close the gap? The answer to this question provided evidence for our recommendations.

Background on the Affordable Care Act

The Affordable Care Act (ACA) was signed into law by President Obama on March 23, 2010, promising increased access to health care through the expansion of health insurance as one of its most important provisions.iii The expansion of health insurance through the individual exchange, expansion of Medicaid, insurance subsidies, and the elimination of pre-existing conditions have increased the number of insured individuals. Enrollment rates are at 11.4 million as of 2015, which greatly exceeds the projected outcome of 9.1 million.iv
Yet, achieving access to medical care continues to be challenge, and the current bipartisan debates threatening a dismantling of the ACA may be only the tip of the iceberg. Even when everyone can agree that improving health care access should be on the national agenda, the political climate and policy feasibility of such measures are not necessarily in sync. The current system resembles what is commonly referred to as a “garbage can model” for healthcare policy in the United States, and particularly in California. Standards and regulations were assembled under the ACA, yet are often disconnected, and at times unrelated to the actual healthcare access needs for low-income, medically underserved populations. An aim of the ACA is the expansion of access to health care, and the legislation is largely centered on insurance reform as a method of generating better access to care.

Multiple provisions within the ACA expand access to health insurance, as legislation:

- “Requires most U.S. citizens and legal residents to have health insurance (excludes “illegal” immigrants, recent immigrants [within 5yrs], and incarcerated populations).”
- “Creates state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals or families with income between 133-400 percent of the federal poverty level (the poverty level is $19,530 for a family of three in 2013).”
- “Creates separate Exchanges through which small businesses can purchase coverage.”
- “Requires employers to pay penalties for employees who receive tax credits for health insurance through an Exchange, with exceptions for small employers.”
- “Imposes new regulations on health plans in the Exchanges and in the individual and small group markets. Expands Medicaid to 133 percent of the federal poverty level.”

As the nation grapples with how to implement the provisions laid out in the ACA, California is presented with a unique policy window to address health care disparities anew and close the access gap for low-income, medically underserved populations. Covered California, the
state based exchange in California, sets their priorities in line with the national objectives in their mission and vision statements as follows:

“Vision: The vision of Covered California is to improve the health of all Californians by assuring their access to affordable, high quality care.”

“Mission: The mission of the Covered California is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.”

While commendable, health insurance does not equal health care access. One can have insurance, but be unable to access health care for a number of reasons including, but not limited to prohibitive costs, prohibitive travel time, socio-cultural barriers, or transportation barriers. In order to ensure that a health insurance plan translates into health care access, state and national regulatory agencies are assigned the responsibility to monitor health insurance plans sold in the marketplace for “network adequacy.”

**BACKGROUND ON NETWORK ADEQUACY**

“Network adequacy” is a health insurance plan’s capacity to meet the needs of its patients through acceptable access to an adequate number of in-network primary care providers, specialty care providers, and all other health services outlined within their contract. When patients are unable to obtain health care services from within their designated network, they suffer out of network costs charged to their accounts, or are “balance billed”. Within the framework of the Network Adequacy standard is an additional standard that outlines minimum requirements for the inclusion of a type of provider called an “Essential Community Provider”.
The expansion of access to health insurance does not necessarily guarantee access to health care. Not only does the expansion leave out certain populations (such as undocumented immigrants), but these newly insured individuals generate an increased demand for healthcare, and physician supply will need to increase simultaneously to meet this demand. One of the aims of the ACA is not only to provide means of purchasing affordable insurance, but introducing regulations to ensure healthcare access for low-income medically underserved populations participating in the Health Benefits Exchange, which is the name of the “marketplace” through which health insurance plans are sold. Please refer to Appendix A for a description of the “marketplace”.

Among these regulations is a standard requiring all health insurance companies to comply with “Network Adequacy” standards, and health insurance plans participating in the Exchange to include a minimum number of safety net providers, whom they call “Essential Community Providers” (ECPs), within their networks. This standard is meant to ensure that the networks of health plans offer feasible, timely access to an adequate number of providers. The regulation is set at the federal level, with latitude at the state level to define the extent of the standard.
The ECP standard falls under Title 45 of the Code of Federal Regulations and is part of the Network Adequacy standard. Figure 1 shows where in Title 45 these regulations are located.

**Figure 1: Location of Standards within Title 45**

**BACKGROUND ON TARGET POPULATION**

The Network Adequacy and ECP provisions are tailored primarily to address the needs of underserved populations accessing health care through the Health Benefits Exchange. Therefore, the target population for this study includes the low-income, medically underserved populations in California who are eligible for subsidized health plans offered through Covered California.

While individuals and families with incomes between 138 and 140 percent of the Federal Poverty Level (FPL) are eligible for premium subsidies to purchase coverage through Covered California, those with income up to 250 percent FPL are eligible for additional cost-sharing subsidies that are available for the Silver 70 Plan1 through Covered California. In addition, the Covered California QHP Model Contract defines low-income populations as those “living at or below 200 percent of the Federal poverty level”, and ECPs should be contracted with “to ensure reasonable and timely access” to healthcare services for these populations. Therefore, individuals earning up to 200 percent of the FPL are not only the target population for the Network Adequacy and ECP standards and of this study, but also the target “consumers” of California’s individual health market, since they are eligible for both premium and cost-sharing subsidies to purchase coverage. Please refer to Appendix B for a description of the QHP Metal Tiers.

---

1 After consulting with an expert, we determined that if well-informed the populations within this study area would be advised to choose the Silver 70 based on income and potential credits
**OUR CLIENT**

Our client, Dr. Richard Baker, is Executive Director of the Charles Drew University (CDU) Center for Health Services Research, Professor and Chairman of the Department of Ophthalmology at CDU of Medicine and Science and has been an enthusiastic participant in discussions regarding fair and equal access to healthcare and the eradication healthcare provider shortages. His research focuses on health disparities among low-income, medically underserved populations, and on identifying interventions to improve access to healthcare for these populations. Dr. Baker is now interested in resolving inefficiencies in the ECP standard and advocating for the creation of truly adequate access to healthcare for low-income, medically underserved populations who have purchased insurance through Covered California, the State-Based Exchange (SBE). In finding the root of these failures, Dr. Baker believes that he can use this report to successfully advocate for the optimization or revision of the current ECP standard that is failing to increase access to care, subsequently realigning part of California’s healthcare delivery system with the goals of the ACA. Dr. Baker believes that the current standards are failing to deliver adequate access because private practice providers are not included as part of the ECP definition. He believes that revising the standard to include private providers would increase access to healthcare because insurance companies would be obligated to contract with private providers in low-income, medically underserved areas, something which they would not be motivated to do without the standard. This report will investigate the potential of this assumption and other methods of optimization to generate a set of recommendations for Dr. Baker.
CHAPTER 2: UNDERSTANDING HEALTHCARE ACCESS AND DISPARITIES

WHAT ARE HEALTH AND HEALTHCARE DISPARITIES?

Health Disparities

“Health is a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity.”

- World Health Organization [WHO], 1948

Public health research demonstrates how various populations are more at risk for certain diseases and often uses the term “health disparities” to articulate these differences. The United States Health Resources and Services Administration (HRSA) defines health disparities as “population specific differences in the presence of disease, health outcomes, or access to health care.” Significant health disparities are most evident in populations who (a) have high barriers to access, (b) belong to a minority group, and (c) live in poverty or below the federal poverty line. Recognizing the importance of eliminating health disparities, the Department of Health and Human Services (HHS) focused on the elimination of health disparities in its Health People Campaign. Moreover, the advancement of efforts to reduce health disparities have been touted as an important component of ACA change and considerable funding has been made available to states for the development of these provisions. In spite of persistent work to improve access to health care, health disparities persist in terms of disease and treatment rates, and disease burden. Eliminating these disparities is already on the state and national agendas, and these efforts provide Covered California and DMHC with a window of opportunity to better optimize legislation surrounding Network Adequacy and ECPs to align with these efforts.


**Healthcare Disparities**

While health disparities refer more to the “burden of illness, injury, disability, and mortality” experienced by different populations, healthcare disparities are defined by differences between populations in accessing quality, affordable care.\textsuperscript{xx} Healthcare disparities are a geographic phenomenon affected by the same political, economic, and social barriers defined above, and are important to address because the disproportionate share of the burden held by underserved populations perpetuates poor health outcomes, worse quality of life, and less access to care.

**HOW IS ACCESS TO HEALTHCARE DEFINED?**

Access to healthcare is defined by political, economic, and social factors and is an “important determinant of health.”\textsuperscript{xiii} The ability to access healthcare is important not only for emergency and chronic care services, but also for prevention of future burden of disease. Preventative health has the potential to lower rates of disease, disability, and preventable death and improves quality of life, life expectancy, and overall health.\textsuperscript{xiv} The major factors that affect access include:

*Table 1: Examples of Factors that Affect Access*\textsuperscript{xv}

<table>
<thead>
<tr>
<th>Factors that Affect Access</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Political</td>
<td>Creation and maintenance of access through implementation of legislation, interests of key stakeholders, and regulation.</td>
</tr>
<tr>
<td>Economic</td>
<td>The ability to obtain insurance, affordability of services and the poverty rate among different populations, timeliness of services, facility capacity and infrastructure, and supply of providers.</td>
</tr>
<tr>
<td>Social</td>
<td>The ability of patients and providers to communicate clearly and effectively, the relationship between patient, provider, and the community, the cultural competency of care including language, and race and ethnicity.</td>
</tr>
</tbody>
</table>
WHAT ARE SOME OF THE BARRIERS TO HEALTH CARE ACCESS?

In parallel to the factors that define access, there are a significant number of barriers to accessing healthcare.

Table 2: Examples of Barriers to Access

<table>
<thead>
<tr>
<th>Type of Barrier</th>
<th>Examples</th>
</tr>
</thead>
</table>
| Political      | • Legislation can generate barriers to care for groups including low-income, medically underserved populations.  
                • Legal obstacles; embers of certain populations, including undocumented individuals, fear legal repercussions if they attempt to access care.  
                • Lobbying of wealthy interest groups can generate legislative barriers.  
                • Gerrymandering affects the creation of adequate networks by creating inefficient service areas. |
| Economic       | • Lack of insurance hinders access to care beyond free safety net services that are often insufficient to meet the needs of underserved populations.  
                • Delays or inability to access preventative care  
                • Hospital stays that could have been prevented  
                • Irregularities and discontinuity in care can perpetuate poor health  
                • Structural barriers that hinder supply and capacity of care.  
                • Financial barriers, including extreme poverty |
| Social         | • Language and the inability to communicate between provider and patient.  
                • Cultural incompetence |

The list of barriers presented in Tables 1 and 2 show that underserved populations face lower levels of access due to a higher burden of barriers. This results in worse health outcomes, increased costs, and lower quality of life, necessitating policies to intervene, which is why the ECP and Network Adequacy standards are extremely important. Given their importance, why have these standards failed to close the access gap and diminished the barriers that vulnerable populations face?
CHAPTER 3: POLICY QUESTIONS

The implementation of the Network Adequacy and Essential Community Provider standards was assumed to significantly increase access to healthcare. The ACA took the initial step in facilitating access to healthcare for low-income, medically underserved populations by making insurance available and affordable; however, it is evident that there is gap being perpetuated by a mismatch between (1) the legislation and implementation of Network Adequacy and Essential Community Provider Standards, (2) the specific needs of underserved populations who have purchased insurance from the Exchange, and (3) the significant increase in demand for healthcare by this population as measured by enrollment in the Exchange. In order to better understand the nature of the gap, it is necessary to first evaluate the mismatches between these three areas. We will then evaluate the policy alternatives based on feasibility and effectiveness and determine which, if any, would best close the gap and increase access to care for underserved populations.

POLICY QUESTIONS

Why are the Network Adequacy and Essential Community Provider Standards failing to close the gap in securing adequate access to care for underserved populations in California, and should policy be optimized or revised to close the gap?

In order to provide a comprehensive answer to this question, we will first answer the following questions.

1. Are the standards being enforced and monitored to the fullest extent, and are any failures in regulatory oversight contributing to the gap in access to healthcare for underserved populations?
2. Are the legal language and evaluation metrics being optimized to increase access to healthcare for underserved populations? Is the language specific, and are there standard units of measurement used to define the different facets of access?

3. Are any types of providers missing or being excluded from the ECP standard who could help increase access? Is this contributing to the gap?

4. Do the standards facilitate the optimal matching of provider supply with the new demand? How might the current number and distribution of providers in SPA 6 demonstrate areas in which the current standards are ineffective? How is supply affecting the gap in access?

An analysis of these questions will determine mismatches and inefficiencies in translating the legislation and implementation of the Network Adequacy and ECP standards into increased access to health care for low-income, medically underserved populations. By addressing the specific inefficiencies of these standards and evaluating possible methods of optimizing the legislation and implementation, we can then propose the best course of action for Dr. Baker.
CHAPTER 4: METHODOLOGY

We collected quantitative and qualitative data from an extensive literature review, key informant interviews, and public databases to answer our policy questions.

LITERATURE REVIEW

We conducted a comprehensive literature review on the implementation of the ACA, the history of Network Adequacy and ECPs provisions, the landscape of healthcare disparities, and healthcare supply and demand. We also reviewed Network Adequacy and ECP standards under both the ACA and the most recent version of Covered California’s rules and recommendations for Qualified Health Plans, which is the name for all plans sold in the State-Based Health Benefits Exchange (Covered California). In addition, we looked specifically at studies conducted in Los Angeles to understand how these key barriers are manifested in SPA 6. We used this literature review to inform our background and introduction, define parameters for our research question, and select our study population, area, and focus. Qualitative data from the literature review also informed the discussion of the problems we found, the construction of our policy options, and led us to a number of key informants.

KEY INFORMANT INTERVIEWS

We conducted over a dozen interviews with key informants including UCLA faculty, professional policy analysts, insurance providers, and regulatory agency representatives. During our interviews with UCLA faculty, we discussed policy analysis methods and frameworks to best address our research question. We also discussed the feasibility and relevance of our policy options. Our interviews with professional policy analysts helped inform our evaluative criteria and data analysis processes, including the construction of our data sets. During these interviews,
we were directed to regulatory agency representatives and supplemental data and literature sources. Interviews with regulatory agencies and the Covered California were the most helpful in understanding monitoring and compliance, as well as confirming the metrics used by each regulatory agency to verify adequate access. Please refer to Appendices C and D for a description of key informants and sample interview questions.

**Quantitative Data Gathering and Processing**

We collected quantitative data on geographic boundaries, demographics, and patient-to-primary care physician ratio from the United States Census Bureau, California Office of Statewide Health Planning and Development (OSHPD), and Los Angeles County GIS Data Portal. We also acquired the latest Covered California Consolidated ECP List January of 2015, which lists each ECP’s location, type, and contact information.² Please refer to Appendix E for a description of data sources and data extraction tools.

² The Covered California Consolidated ECP List is issued by Covered California on Feb. 9th, 2015. Source: http://hbex.coveredca.com/stakeholders/plan-management/ecp-list/
CHAPTER 5: ARE THE NETWORK ADEQUACY AND ESSENTIAL COMMUNITY PROVIDERS REGULATIONS EFFECTIVE?

CATEGORY 1. ARE THE NETWORK ADEQUACY REGULATIONS EFFECTIVE?

Methods of evaluation

To define the regulatory structure and methods of measuring and monitoring compliance with the Network Adequacy and ECP standards, we conducted a series of interviews with key stakeholders and a comprehensive literature review. This process revealed the continued problems facing enforcement and implementation.

How is Network Adequacy regulated?

The network adequacy of all health insurance plans sold in California, including those on the State Based Exchange (SBE), is certified and monitored by three different regulatory agencies. These include: Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), and California Department of Insurance (DOI).

DMHC and DHCS are departments within the California Health and Human Services Agency (CHHS), and DOI is its own agency. While DHCS and DOI regulate and monitor compliance with network adequacy standards for Medi-Cal and ‘private’ health plans, DMHC regulates network adequacy for all QHPs on the State Based Exchange (SBE), and Covered California (which is not an agency) enforces the ECP provision for all QHPs. Figure 8 below shows the regulatory oversight of each agency with regards to network adequacy and the ECP standard.
To become certified, plans are reviewed by DMHC and approved based on the plan’s compliance with various guidelines set by the Centers for Medicare and Medicaid Services (CMS) and as outlined in *Title 28: Managed Health Care*. As an additional measure, plans sold in the State Based Exchange must meet certain additional guidelines as outlined in Covered California’s model contract. Network sufficiency is assessed along three separate measures within a plan: (1) sufficient providers, (2) providers and specialists that fulfill service area needs, and (3) timely access to care (*Figure 9*):
• **Sufficient providers**- DMHC requires all health plans to submit an up-to-date list annually of every health network that they have with every provider. The law also requires insurance companies to report quarterly any ten percent increase or decrease in the number of providers within their network, however, DMHC reports that this relies on self-reporting rather than any active monitoring by DMHC. Additionally, the list reports all full-time providers, and “full-time equivalent” providers, however, DMHC described to us in an interview the extent to which determining full-time equivalence can be difficult given the ways that physicians are moving targets, their time often split between locations.

• **Providers and specialists that fulfill service area needs**- The metrics defined for geographic distance are over forty years old. Having been developed in the 1970s,

---

3 This figure shows how DMHC appraises QHPs for “sufficient” networks, a process that was constructed from multiple legal codes including §156.230, 2702 (c) of the PHS Act, and Title 28.
population density increases makes it so that insurance companies can easily comply with the standard without actually contracting with providers in underserved areas.

- **Timely access to care** - Timely access to care is defined as 15 miles or 30 minutes to a provider from work or from home as listed in *Title 28.* DMHC sets this as a guideline, but is only for the certification process. Once a plan is certified, it appears that the timely access to care provision is not reviewed again unless a plan undergoes review following a complaint filed against it.

Once certified, an insurance plan is reviewed periodically to assess for compliance. Previously, the review process occurred every three years, but identifying a need to increase oversight and compliance, as of September 2014, California Senate Bill 964 increased formal reviews to yearly. Still, the health plans are usually approved without a review unless the agency receives an external complaint from patients, or, should the insurance company choose to ask for an evaluation.

**Is the Network Adequacy Standard Enforced?**

Our client would like to see the Network Adequacy standard optimized to better close the gap on health care access disparities; however, a review of the regulatory standards for Network Adequacy in California suggest that the standard might not be enforced to the fullest extent. In an interview with a representative from the licensing office at DMHC, it was made clear in several examples that enforcement privileges are not utilized. First, if a health plan fails to meet the Network Adequacy standards listed earlier, it may continue to be sold on the market pending a written explanation as to why the plan cannot fulfill the requirement. This is due in part because DMHC reports constraints in enforcement of the standard when deficiency relies on ambiguous language such as “reasonable” and “sufficient” number of providers. Yet, not only
does DMHC lack clearly defined penalties for noncompliance, but further, the agency claims that it would simply offer “corrective action” techniques if it found a plan to be noncompliant rather than remove the plan from the market. DMHC admits to never having penalized an insurance company and never having exercised their authority to remove a health plan from the market. In essence, any explanation for noncompliance is permissible by the agency, suggesting that regulatory oversight is nonbinding for insurance companies; they do not feel constrained by the standard.

However, the newly signed Senate Bill 964 requires insurance companies to send DMHC updated lists of providers each year to facilitate monitoring, rather than having DMHC initiate a review every three years.\textsuperscript{xxxvi} The Bill’s aim is to resolve the information and access failures identified within the system thus far, including the omission of providers unable to take on new patients previously included within a network. DMHC is hopeful that this new bill will remove some ambiguity and strengthen regulatory oversight, binding insurance companies to the standard. The bill also acts as a paper trail to assess an accurate estimate of the supply of providers within each health plan network and region.

**CATEGORY 2: IS THE ESSENTIAL COMMUNITY PROVIDER REGULATION EFFECTIVE?**

*Method of Evaluation*

To best understand the ECP legislation and its regulation, we surveyed the legal text surrounding the ECP standard, the QHP model contract, which lays out Covered California’s ECP requirements, and relevant issue briefs that discussed the importance of including ECPs in health plan networks. We also analyzed available ECP data sources, including the federal and state “non-exhaustive consolidated list” of ECPs to discern the type, number, and geographic
location and variation of ECPs within California. Finally, a series of interviews with key stakeholders allowed us to define the regulatory structure and confirm methods of measuring and monitoring compliance, which in turn revealed inefficiencies facing enforcement and implementation.

**How is the ECP Standard Regulated?**

The Plan Management Division within Covered California is responsible for the regulation of the ECP standard and has a small staff that oversees certification and monitoring. Covered California is the name given to California’s State Based Health Exchange, which was enacted through Senate Bill 900, Chapter 659 and Assembly Bill 1602, Chapter 655 to certify all QHPs sold in the marketplace. Although it is not a regulatory agency, Covered California has the sole discretion to define, measure, and monitor the ECP standard through the purview of its authority over the QHPs sold in the marketplace. This is separate from the oversight of network adequacy monitored by DMHC, and it is assumed that a plan has met those standards before it can apply to be sold in the marketplace.

In compliance with the state definition of ECPs, to be certified by Covered California, QHPs must contract with: (1) at least 15 percent of 340B entities per geographic region proposed by a QHP bidder; (2) at least one essential community provider hospital per region; and must demonstrate (3) a minimum proportion of QHP network overlap among QHP networks and ECP networks as defined in Figure 10 below:

---

4 Entities that participate in a reduced-rate prescription drug program.
Covered California publishes a non-exhaustive list of ECPs meant to capture all providers with an ECP designation to assist insurance companies in selecting ECPs for their networks. Like Senate Bill 964, this list also helps Covered California keep track of provider supply, variation, and distribution within each health plan network service area and region. Key informant interviews with representatives at Covered California confirmed that the service area for a QHP network is either at the County or Rating Region level, though it is unclear where the discretion lies in selecting which to use. Having established a set of ECP standards and a denominator for meeting the 15 percent requirement, Covered California created a model contract to certify plans that it revises each year to meet current regulations. This contract outlines all of the standards that a QHP must meet in order to be certified, including the ECP standard. With regards to monitoring compliance during the calendar year, Covered California conducts quarterly surveys to ensure that all plans sold through the marketplace are in compliance with

<table>
<thead>
<tr>
<th></th>
<th>The Center for Medicare &amp; Medicaid Services (CMS) non-exhaustive list of available 340B providers in the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs.</td>
</tr>
<tr>
<td>4</td>
<td>Community Clinic or health center licensed as either a “community clinic” or “free clinic”, by the State of California under Health and Safety Code section 1204(a), or is a community clinic or free clinic exempt from licensure under Section 1206.</td>
</tr>
<tr>
<td>5</td>
<td>Physician Providers with approved applications for the HI-TECH Medi-Cal Electronic Health Record Incentive Program.</td>
</tr>
<tr>
<td>6</td>
<td>Federally Qualified Health Centers (FQHCs).</td>
</tr>
</tbody>
</table>
the ECP standard. Starting in 2016, Covered California will introduce a set of “performance guarantees” to improve the oversight of plan certification in meeting minimum standards.xi

**What are the differences between the federal and state based definitions of ECPs?**

The federal and California state standards and definitions of ECPs differ. The text of legal code §156.235 from the ACA states that as part of Network Adequacy standards, all QHPs, state and federal, must include a “sufficient number and geographic distribution” of ECPs. In addition, this distribution must account for “reasonable and timely access” to a “broad range” of providers.xii In the Federally Facilitated Marketplace (FFM) there is a Safe Harbor Law⁵ that states that QHPs must contract with:

1. 30 percent of all Essential Community Providers in a “service area”;
2. All Indian Health Providers; and
3. One each from each category⁶.

As a state-based exchange, however, California has the discretion to define its own standards, and as the first State Based Exchange, Covered California had actually set ECP standards before the federal standards had been defined as they are today. Due to California’s speed in establishing standards, there are considerable differences between the federal and state ECP standards, and California unintentionally created less stringent standards. While similar, California tailored the definition and “safe harbor” requirement for Essential Community Providers to “better” meet the needs of underserved populations in California.xiii However, California did base its standards off of the six major federal categories of ECPs, which include:

---

⁵ A provision that states that certain behaviors will not go against the law, it goes hand in hand with vague language.
⁶ Categories described in Table 4
Table 4: Description of Major Federal ECP Categories

<table>
<thead>
<tr>
<th>Major ECP Category</th>
<th>ECP Provider Types</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federally Qualified Health Center (FQHC)</td>
<td>FQHC and FQHC “look-alike” clinics, outpatient health programs/facilities operated by Indian tribes, tribal organizations, and programs operated by urban Indian organizations.</td>
</tr>
<tr>
<td>Ryan White Provider</td>
<td>Ryan White HIV/AIDS program providers</td>
</tr>
<tr>
<td>Family Planning Provider</td>
<td>Title X family planning clinics and Title X “look-alike” family planning clinics.</td>
</tr>
<tr>
<td>Indian Health Provider</td>
<td>Indian Health Service (IHS) providers, Indian tribes, tribal organizations, and urban Indian organizations</td>
</tr>
<tr>
<td>Hospital</td>
<td>Disproportionate share hospital (DSH) and DSH-eligible hospitals, children’s hospitals, rural referral centers, sole community hospitals, free-standing cancer centers, and critical access hospitals.</td>
</tr>
<tr>
<td>Other ECP Provider</td>
<td>STD clinics, TB clinics, hemophilia treatment centers, black lung clinics, and other entities that serve predominately low-income, and medically underserved individuals.</td>
</tr>
</tbody>
</table>

Please Refer to Appendix F for chart of the major differences between the Federally-Facilitated Marketplace and Covered California.

Is the Essential Community Provider Standard Effective?

While the ECP standard has the potential to ensure low income medically underserved populations have access to health care within their network, a number of inefficiencies persist preventing the realization of this goal.

Regulatory Oversight.

Covered California has a system in place to monitor compliance on a consistent basis, as well as a set of financial penalties if a QHP is found to be non-compliant. However, to date, no plan has been penalized for non-compliance, and Covered California reports that it would prefer to work with QHPs to help them meet the standard instead of penalizing them at this early stage.

---

7 This table was taken from the 2014 CMS Letter to Issuers on the Federally Facilitated Exchange. We have included it to show differences between the federal and California ECP standard.
in its development. Without an enforcement penalty, however, insurance companies will have no incentive to strive for compliance. Covered California risks losing its window to establish a precedent of enforcing penalties for noncompliance, and as a result the ECP standard could continue to be nonbinding for insurance companies.

Another issue with regulatory oversight includes data inefficiencies. A non-exhaustive list of ECPs developed by Covered California divides providers into three categories: hospital ECPs, non-hospital ECPs, and Hi-Tech Incentive Program Providers. The most recent list includes 2,422 providers. A provider is automatically listed as an ECP if they are a 340B provider, and the burden is on individual providers to ask to be added to the list if they are not in the 340B program but fit another category such as a Hi-Tech Incentive Program Provider. Therefore, the true supply of ECPs might not be accurately reflected at any given point. Moreover, the list is misleading because some Hi-Tech Incentive Program Providers are also counted on the non-hospital ECP list, and in a screen for double counting, the list drops from 2,422 providers to 1,232. This inefficiency suggests that the distribution and availability of ECPs to be contracted with is much smaller than it appears. After cold calling providers designated as ECPs on the list, we discovered that none of them were aware of the ECP standard, and often the contact person listed varied from “director” and “clinic supervisor” to “pharmacy director” and “pharmacist”, with the individuals fulfilling those roles unaware of the fact that their clinics were designated as ECPs or that they had been listed as a primary contact for their ECP. Although the extent of the importance of the “primary contact” person on the list is unclear, if patients or insurance companies are required to use this list to identify providers, then it is important that the list be accurate. A possible root of the problem is that the Plan Management Division within Covered California sees the ECP standard as a certification requirement rather than a legal
requirement and means of addressing the access gap, so regulatory enforcement is not as effective as it could be. Please refer to Appendix G for a Stata Log for double counting.

Legal Language and Metrics.

Similar to Network Adequacy, the vague language and unclear metrics of the ECP standard make it difficult to regulate. While a representative confirmed that “sufficient” corresponds to the inclusion of 15 percent of all 340B providers per service area requirement, the ambiguous language makes it difficult to enforce the standard. While discretion is necessary to limit inefficiencies, when language is too vague, and the administrative burden too high, it is difficult to bind regulation with the law. The 15 percent minimum is also very low and does not allow for as much variation and distribution in provider type for plan networks. Insurance companies have the ability to design plans that meet the minimum requirements without capturing the spirit of the standard, which is to improve access to care for low-income, medically underserved populations.

Additionally, we were given two different responses when determining the size of a service area, suggesting inefficiencies in the metrics used to certify that QHPs meet the minimum ECP standard. It is unclear whether the service area is a zip code along county lines, or a Rating Region, and the difference between the two areas is very large in the context of constructing an adequate network that has a “sufficient” number and distribution of ECPs. These unclear metrics render the standard less effective than it was designed to be in delivering access to care.

Providers Included in the ECP Definition

The ECP standard lists a number of different provider types that meet the definition and are counted towards the 15% inclusion minimum in California. A key informant from Covered California noted that the ECP standard is new and therefore still in flux; however, the
unintended exclusion of certain types of providers has made it difficult for the standard to generate an optimal distribution of providers in each network. For example, California does not have the “one per category” requirement that the federal standard requires. This means that QHPs are not required to contract with important safety net providers including Family Planning Clinics and Ryan White HIV Clinics. Single-service providers are an integral part of safety net care delivery because they provide specialized services to vulnerable populations through extra competencies tailored to the needs of these populations. An interview with the Kaiser Family Foundation pointed out the importance of Title X Family Planning clinics that play a crucial role delivering family planning care, including pre and post-natal care. The unintended exclusion of these clinics make it more difficult for low-income, medically underserved populations to access necessary family planning care, and does not reflect the true supply of providers who meet the needs of this population. Thus, an inefficiency emerges as a consequence of establishing standards before the federal guidelines were published; Covered California intended to improve access by expanding the ECP definition, but may have left out key providers.

In addition, many private providers have been “excluded” from the standard because they do not meet the current definition. The Hi-Tech Incentive Program does include private providers, but not all are able to afford the technology and feel that they are being excluded from QHP networks in lieu of other ECPs. Private providers are important because they often have well-established relationships with patients in the community and are important for providing continuity of care within the context of healthcare reform. Our client has voiced a special concern about the exclusion of private providers, as he believes that they are an integral piece of the safety net community, and their exclusion from the ECP definition has made it difficult to join the networks utilized by their patient population. The interruption of care continuity and
reduced network variety due to exclusions negatively impacts access, and while the inclusion of private providers includes some controversy, it is leading to inefficiencies in the ECP standard.

**CONCLUSION**

In theory, the Network Adequacy and ECP standards have the potential to address healthcare access disparities in California, but the regulatory atmosphere and technical design of the standards limit their enforcement and effectiveness. California is often looked at as a primary example of leadership and innovation in policy, and yet it appears that these two standards are not effectively translating legislation into increased access to healthcare, suggesting that another factor is at play. It is therefore important to identify other factors that are hindering California’s success in delivering access to healthcare as an additional means of determining how to optimize the legislation.
CHAPTER 6: THE EFFECT OF PROVIDER SUPPLY ON NETWORK ADEQUACY AND THE ESSENTIAL COMMUNITY PROVIDER STANDARD

Our literature review revealed that provider supply, both federally and within California, is cited as one of the primary problems that hinders the effectiveness and success of ACA legislation. An analysis of the provider supply issue in California within the context of the Network Adequacy and ECP standards will inform our evaluation of potential methods of optimization.

THE WORSENING PRIMARY CARE PHYSICIAN SUPPLY SHORTAGE

As the American population increases, ages, and becomes more insured, the demand for primary care providers is estimated to increase as well.\textsuperscript{xlvii} Research has indicated that primary care providers play an important role in ensuring that greater insurance coverage translates into improved healthcare access.\textsuperscript{xlvii} For example, an empirical study done in upstate New York suggests that a larger primary care provider supply is associated with increased numbers of primary care visits as well as utilization of preventive services.\textsuperscript{xlvii} Due to the increased demand, it is predicted that the primary care physician supply will not able to meet this demand, and the projected supply shortage for 2020 will exceed 20,400.\textsuperscript{xlix} Another study estimates that the United States may encounter a shortage of primary care physicians as high as 45,000 by 2020.\textsuperscript{1} Therefore, we must consider how the provider shortage in California will affect the design and projected implementation of any optimization methods.
**HEALTH PROFESSIONAL SHORTAGE AREAS**

While estimates of projected needs for primary care vary, the growing shortage of physician supply has long been a focus of policy makers. In order to identify geographic areas, population groups, and medical facilities that are experiencing shortages of health professionals, HRSA established criteria for the designation of Health Professional Shortage Areas (HPSA).\(^\text{i}\) Research also indicates that low-income or rural communities tend to face higher level of primary care physician shortages.\(^\text{ii}\) Many federal and state programs use the HPSA designation to direct assistance and incentives in order to bring in more providers in underserved areas.

According to the criteria for a HPSA designation, a geographic area is considered to be experiencing a physician shortage if its patient to primary care physician ratio is at least of 3,500:1. An area with a patient to primary care physician ratio between 3000:1 and 3500:1 will also be identified as experiencing a physician shortage if this area shows high needs for primary care services.\(^\text{iii}\) On the health plan side, both the Knox-Keene Act and the Insurance Code and Regulation require that an adequate network have a patient to primary care physician ratio of at least 2000:1.\(^\text{iv}\) In order to have an adequate network, it is necessary to have an adequate supply. We examined the extent of primary care physician shortages in California based on the criteria used for HPSA designations and the standard ratio for the Network Adequacy regulation. *Figure 2* shows the classification of primary care shortage severities.

---

\(^\text{i}\) The Network Adequacy requirement on patient to primary care physician ratio is summarized in Final Recommendations on Qualified Health Plan Policies approved by California Health Benefit Exchange Board. Retrieve from: file:///Users/zhenghuixin/Desktop/FinalBRB-QHPoliciesandStrategies_8-23-12.pdf
Table 3: Classification of Primary Care Shortage Severity

<table>
<thead>
<tr>
<th>Ratio of Patients to Primary Care Physicians</th>
<th>Shortage Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,000:1 or less</td>
<td>Adequate network</td>
</tr>
<tr>
<td>2,000:1 to 3,000:1</td>
<td>Acceptable but not meeting Network Adequacy standards</td>
</tr>
<tr>
<td>3,000:1 to 3,500:1</td>
<td>Designated as HPSAs if experiencing high needs for primary care</td>
</tr>
<tr>
<td>3500:1 or above</td>
<td>Designated as HPSAs</td>
</tr>
</tbody>
</table>

The California Office of Statewide Health Planning and Development (OSHPD) collects data on the patient-to-primary care physician ratio at the Medical Service Study Area (MSSA) level. Using data available from OSHPD and the classification criteria described in Table 3, we mapped the patient-to-primary care physician ratio shortages in California at the MSSA level in Figure 2. This map of California illustrates how approximately 30 percent of MSSAs in California do not meet the current network adequacy standards that require a patient-to-primary care physician ratio.
care physician ratio that is no greater than 2,000:1, as illustrated in pink and maroon on the map.

Additionally, there are areas across California that qualify as primary care HPSAs but are not being designated as such (Figure 3). This is important because it suggests that the true magnitude of the shortage is being obscured in the absence of official designations. Without the HPSA designation, these areas will have more difficulty attracting new physicians since there are fewer incentive programs in place, and populations in these areas are likely to have higher risks and poorer health outcomes. The extent of HPSA shortages in California therefore indicates that while the Network Adequacy and ECP standards are designed to increase access to healthcare, this is incredibly difficult to achieve in the provider supply cannot meet the needs of the legislation.
HEALTHCARE DESERTS

Our client is primarily concerned with how the Network Adequacy and ECP standards can increase access to care for low-income, medically underserved populations in Los Angeles. While HPSA accounts for primary care physician shortages, health care access takes into account more than just this ratio, and an analysis of access in a low-income, medically underserved area of Los Angeles further indicates the impact of provider supply on healthcare access. The term healthcare desert is akin to others used to describe geographic areas where people have difficulty obtaining or accessing a specific type of resource. For example, Food deserts are geographic areas devoid of affordable and nutritious food, and usually exist in rural and underserved communities. Similarly, we define healthcare deserts as areas where timely and affordable access to quality healthcare services is not guaranteed, particularly for underserved populations. Given the available data, we considered three dimensions to identify potential healthcare deserts: total population, percentage of population with income between 100% and 200% FPL, and patient-to-primary care physician ratios. Based on these determined dimensions, we conducted a hot spot analysis for Los Angeles County. Areas with a large population, large percentage of low-income population, and high patient to primary care physician ratios are most likely to be identified as a hot spot cluster, or healthcare desert.

Through an investigation of the healthcare landscape within Los Angeles County, we can identify areas of greatest need that can be used as a case study to determine the extent to which the Network Adequacy and ECP standards can or cannot close the gap for health care access.

---

9 Due to data availability, we used the percentage of people with income between 100% and 200% FPL as a proxy for low-income populations that are not eligible for Medi-Cal but eligible for subsidies for plans offered through Covered California. (In reality, the population is comprised of people with income between 138% and 200% FPL as described in the Introduction)

10 Hot spot analysis has been used in the field of public health to identify locations of statistically significant clusters that require extra attention. See example: Stopka, Thomas J., Christopher Krawczyk, Pat Gradziel, and Estella M. Geraghty. 2014. 'Use Of Spatial Epidemiology And Hot Spot Analysis To Target Women Eligible For Prenatal Women, Infants, And Children Services'. Am J Public Health 104 (S1): S183-S189. doi:10.2105/ajph.2013.301769.
Figure 4 models areas with the greatest need for healthcare resources identified through hot spot analysis by creating a “Health Desert Score”, as defined in the text box of Figure 4.

**Figure 4: Modeled Healthcare Deserts in Los Angeles**

As indicated on the map above, Service Planning Area 6 (SPA 6)\(^{11}\) is one of the areas with the highest health desert scores as defined by our hot spot analysis and is thus identified as one of the most severe healthcare deserts in Los Angeles County. The networks of all QHP's in

\(^{11}\) A Service Planning Area, or SPA, is a region within Los Angeles County. The Department of Public Health develops healthcare programs based on specific needs of people residing in these different areas. Source: http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm
SPA 6 are currently certified as adequate, and yet severe healthcare deserts persist, suggesting that Network Adequacy and ECP standards are failing to close the gap.¹⁴

**SOUTH LOS ANGELES AND SERVICE PLANNING AREA 6**

Los Angeles County is divided into eight geographic service planning areas, or SPAs (Figure 5).

![LA Department of Public Health Map of Service Planning Areas (SPAs) in Los Angeles County](image)

Previous studies indicate that SPA 6, as home to more than a million people, faces some of the greatest healthcare and socio-economic challenges in Los Angeles and California, making it a representative example of the underserved populations that the Network Adequacy and ECP standards are trying to reach. Compared to other SPAs in the county, SPA 6 is
disproportionately disadvantaged due to disparities in socio-economic conditions and racial segregation in Los Angeles. Our hot spot analysis also highlights the relatively high demand for healthcare services in SPA 6. Figure 6 compares the demographics between SPA 6 (South LA) and SPA 5 (West LA).

*Figure 6 Demographics in Los Angeles County by SPA, 2006*

<table>
<thead>
<tr>
<th></th>
<th>SPA 5 / West LA</th>
<th>SPA 6 / South LA</th>
<th>LA County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>636,309</td>
<td>1,041,685</td>
<td>10,174,823</td>
</tr>
<tr>
<td>Latino Population</td>
<td>17.4%</td>
<td>63.6%</td>
<td>37.6%</td>
</tr>
<tr>
<td>White Population</td>
<td>63.2%</td>
<td>2.2%</td>
<td>31.6%</td>
</tr>
<tr>
<td>African American Population</td>
<td>6.5%</td>
<td>32.4%</td>
<td>15.3%</td>
</tr>
<tr>
<td>Asian/Pacific Islander Population</td>
<td>12.7%</td>
<td>1.6%</td>
<td>15.1%</td>
</tr>
<tr>
<td>American Indian/Alaskan Native Population</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Population with incomes less than 100% FPL</td>
<td>10.3%</td>
<td>28.3%</td>
<td>16.0%</td>
</tr>
</tbody>
</table>


The percentages in the figure above highlight the stark demographic differences between SPA 6 and SPA 5 along racial, ethnic, and socio-economic lines. As indicated by Figure 6 above, in 2007 SPA 6 had a much higher percent of Latinos and African Americans as well as individuals with incomes less than 100 percent of the FPL than the county and SPA 5 in West LA. Residents in SPA 6 also have poorer health status and less access to health care compared to other Angelinos (*Figure 7*).
As shown in Figure 7 above, compared to other Angelenos, a much larger percent of residents in SPA 6 reported fair or poor health outcomes and difficulties in accessing to medical care. SPA 6 also had the highest percent of uninsured population aged between 18 and 64 in 2007.\textsuperscript{15} However, with the establishment of the State Based Exchange and subsidies for low-income populations to purchase health insurance through the Marketplace, many of the previously uninsured populations in SPA 6 are expected to obtain health coverage. Therefore, it’s imperative that expanded coverage be translated to access for these newly insured population through implementing the ACA effectively.

Issues including poor education and literacy, coupled with language deficiencies and cost burdens further decrease access for this population. These discrepancies lead to delays in accessing medical care, which can perpetuate significant health problems. Within the healthcare system of SPA 6, clinics and hospitals experience supply side problems including low numbers of Emergency Department (ED) stations, limited numbers of beds for inpatient services, wait times

---

### Indicators of Health Status and Access to Care

<table>
<thead>
<tr>
<th></th>
<th>SPA 1</th>
<th>SPA 2</th>
<th>SPA 3</th>
<th>SPA 4</th>
<th>SPA 5</th>
<th>SPA 6</th>
<th>SPA 7</th>
<th>SPA 8</th>
<th>LA County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of adults reporting their health to be fair or poor</td>
<td>16.0</td>
<td>15.8</td>
<td>19.4</td>
<td>22.8</td>
<td>7.4</td>
<td>27.1</td>
<td>19.1</td>
<td>17.4</td>
<td>18.5</td>
</tr>
<tr>
<td>Percent of Children perceived by their parents to be in fair or poor health</td>
<td>5.9</td>
<td>5.7</td>
<td>8.4</td>
<td>9.2</td>
<td>2.7</td>
<td>12.3</td>
<td>10.1</td>
<td>8.2</td>
<td>8.4</td>
</tr>
<tr>
<td>Percent of adults ages 18-64 who are uninsured</td>
<td>13.6</td>
<td>17.7</td>
<td>22.5</td>
<td>31.4</td>
<td>11.8</td>
<td>32.9</td>
<td>24.2</td>
<td>17.9</td>
<td>22.0</td>
</tr>
<tr>
<td>Percent of adults with no regular source of healthcare</td>
<td>16.3</td>
<td>17.3</td>
<td>19.0</td>
<td>25.9</td>
<td>18.7</td>
<td>20.9</td>
<td>19.4</td>
<td>16.5</td>
<td>19.2</td>
</tr>
<tr>
<td>Percent of adults who reported difficulties accessing to medical care</td>
<td>29.0</td>
<td>21.8</td>
<td>30.6</td>
<td>33.3</td>
<td>13.8</td>
<td>38.8</td>
<td>27.2</td>
<td>25.7</td>
<td>27.3</td>
</tr>
</tbody>
</table>

of over six months to one year for specialist visits, and a high demand for primary care, indicating an inadequate supply of ambulatory services. Moreover, the high violence and homicide rate in SPA 6 is not met on the delivery side, as trauma care is extremely inadequate to care for the population.

Overall, an assessment of the social, economic, and health-related landscape of SPA 6 in relation to the ACA’s Triple Aim allows us to define specific barriers to the Network Adequacy and ECP provisions and the generation of adequate networks through Covered California: (1) Anthem Blue Cross of CA, (2) Blue Shield of California, (3) Chinese Community Health Plan, (4) Health Net, (5) Kaiser Permanente, (6) L.A. Care Health Plan, (7) Molina Healthcare, (8) Sharp HealthCare, (9) Valley Health Plan, and (10) Western Health Advantage.
CHAPTER 7: POTENTIAL AREAS OF OPTIMIZATION WITHIN THE ECP AND NETWORK ADEQUACY LEGISLATION

Having discussed the successes and shortcomings of the Network Adequacy and ECP standards, and the effect of provider supply on implementation of legislation, the following section evaluates each of the optimization focuses for Network Adequacy and the ECP standard to determine the best course of action. Evaluation will include some specific solutions for optimization listed in the table below, and will consider feasibility, benefits and tradeoffs, and potential impact on access.

Table 5: Summary of Potential Areas of Optimization

<table>
<thead>
<tr>
<th>Category</th>
<th>Focus of Optimization</th>
<th>Specific Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Adequacy Standards</td>
<td>Regulatory Oversight</td>
<td>• Establish penalties and fines for noncompliance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Create corrective action plans for Network Adequacy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Change burden of monitoring 10 percent +/- reporting to DMHC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increase frequency of monitoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Utilize technology for up-to-date reporting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Develop system to improve tracking of “equivalent” physicians</td>
</tr>
<tr>
<td></td>
<td>Legal Language</td>
<td>• Create specific definitions for vague language</td>
</tr>
<tr>
<td></td>
<td>Metrics</td>
<td>• Create a consistent unit of measurement (denominator) for service areas by using MSSAs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Update the metrics used to determine adequacy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Data clean up</td>
</tr>
<tr>
<td>Essential Community Provider Standards</td>
<td>Regulatory Oversight</td>
<td>• Increase infrastructure for monitoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Develop monitoring system that aligns with DMHC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Produce up-to-date, accurate data on the list of ECPs published by Covered California</td>
</tr>
<tr>
<td></td>
<td>Legal Language</td>
<td>• Create specific definitions for vague language</td>
</tr>
</tbody>
</table>
### Metrics
- Create consistent unit of measurement (denominator) for service area by using MSSAs

### Provider Expansion
- Bring Single Service Provider requirement into the state ECP requirement
- Bring certain private providers into the law by expanding ECP definition
- Add Nurse Practitioners and/or Physician Assistants, minute clinics (Walgreens, CVS, etc)

---

**Area of Optimization: Regulatory Oversight of Network Adequacy**

**Is it feasible?**

Improving the regulatory oversight of the Network Adequacy standard is somewhat feasible for DMHC at the cost of increased staffing requirements at DMHC and for insurance companies; however, the effectiveness of increased oversight is contingent upon clearer legal language, more realistic penalization policies, shifting the burden of reporting, and ultimately, on an overhaul of physician hour reporting. For example, in conversations with a DMHC representative from the licensing office, the agency cited difficulty enforcing penalties on insurance companies against a standard that simply calls for a “sufficient” number of providers, the ambiguous language leaving the evaluation up to interpretation for determining when a plan is noncompliant.\textsuperscript{xiii}

Further, under the current penalization system, an insurance company is at risk of being removed from the market if it does not meet criteria. Increasing enforcement triggers would occur at the cost of patients losing insurance plans unless the penalty system were to change from a binary system of compliance – where the insurance companies are either meeting or failing to meet adequacy – to something with more options for recourse that still incentivize compliance. Until this change occurs, regulatory agencies will continue allow insurance companies to fail on compliance in order to prevent complete removal of a plan from the market.
Once certified, review of a plan’s network adequacy relies on an external enforcement trigger – consumer complaints, as well as an internal enforcement trigger – insurance company self-reporting. As long as the burden of costs for penalties are concentrated with the insurance companies, who have an incentive to keep regulatory oversight low to control costs, enforcement might continue to be low. Therefore, improving network adequacy in plans is contingent upon shifting the burden of compliance off of insurance companies to self-report and on to DMHC to monitor. Increased compliance of regulatory standards would be at the cost of increased monitoring by DMHC if they were to have to go into the field and evaluate every insurance company rather than only those that had a reported problem.

Finally, the extent to which improved monitoring of physician numbers and type within a network would be feasible is unclear. As explained by a representative at DMHC, physicians are somewhat of a moving target, and the inadequate list of providers may be more of a reflection of the clinical landscape than a reflection of poor data monitoring. For example, one physician may work part-time at multiple locations over the course of a year, and his or her hours may change, making it nearly impossible to calculate actual full-time equivalency. Improving regulatory oversight at DMHC to improve network adequacy is feasible, but is contingent upon other changes including more clearly defined legal language, increased staffing at DMHC, and potentially changing physician hour reporting.

**What are the benefits and tradeoffs?**

Improved regulation of network adequacy by DMHC has the potential to protect patients from “balance billing” which, as previously discussed, is when patients are required to pay out of pocket for a provider who turns out to be out of their insurance network. Optimized network adequacy also has the potential to protect insurance companies from lawsuits such as those
endured by both Blue Shield and Health Net, who were accused of having inadequate networks.\textsuperscript{lxiv lxv 12}

Each change in regulatory oversight for the benefit of improved regulatory oversight has its potential tradeoffs. In addition to the increased burden of cost to DMHC to monitor insurance companies, increased regulation to meet network adequacy criteria would increase the burden of cost to insurance companies to monitor changes in physician work behaviors and to continuously educate patients of any changes made to the network. If DMHC starts to exercise their authority to penalize an insurance company and this results in their being removed from the market, a potential tradeoff includes lost continuity of care for patients, or at a minimum, an increased burden of paperwork to switch insurance carriers should their carriers be removed.

\textit{Will improved regulation of Network Adequacy result in improved access to healthcare for low-income medically underserved patients?}

Increased monitoring and oversight of insurance plans to meet network adequacy criteria has the potential to protect patients from the costs associated with out-of-network charges, however, improving access to health care, the core objective of these regulations relies on the adequate supply of health care providers within a network to see patients in need. No matter how clear and strict the guideline might be, the regulation would likely have little impact on access if the expectation is unrealistic and the supply is not available. For example, the current standard for acceptable wait time for a visit with primary care provider is ten days for a primary care appointment, however, a representative at DMHC explained how average wait times to see primary care providers in California can be up to six months, and a much longer wait time to see a specialist as a result of short supply. Therefore, any change to the regulatory mandate will not be a binding requirement unless the supply increases. While often beneficial to optimize the

\footnote{12 Both insurance companies were sued for false information with regards to the provider composition of their networks.}
regulation of any standard, improving regulation of network adequacy without addressing the provider supply issue first will only impact DMHC’s organizational capacity. It will not incentivize or bind insurance companies to include a truly “sufficient” number and distribution of providers for health networks that include low-income, medically underserved populations.

**Area of Optimization: Legal Language of Network Adequacy**

*Is it feasible?*

The Network Adequacy standards, set in place by the Federal Government, state that insurance providers must maintain a “sufficient” number and types of providers. Upon our evaluation and interview with a DMHC representative, we find that changing this ambiguous language to a more specific definition within the legal text would be a feasible consideration. With added amendments, DMHC would be able to fully implement a less vague standard, replacing “sufficient” with a more concrete definition, and more effectively binding insurance companies to the minimum network adequacy requirements.

*What are the benefits and tradeoffs?*

There are potential tradeoffs with the implementation of a more specific definition for the standard. Adding specifics has the potential to take away discretion from DMHC and insurance companies to come to a sustainable solution. With more specific requirements in place, the regulatory agency may be prohibited from choosing the best course of action for network adequacy. We understand that while discretion is required to limit inefficiencies, when the language is too vague, and the administrative burden is high, it is difficult to bind the state regulatory agency to the law. As mentioned, the federal legislation requirements for network adequacy allow states to choose the extent of implementation, and multiple stakeholders in
California have raised a concern over the lack of clarity as a result of the term “sufficient” as well as an absence of a clear definition of what “sufficient” means, without which a robust assessment of the extent of the problem and opportunities for improvement are prohibitive.

Will improving the legal language of the Network Adequacy standard result in improved access to healthcare for low-income medically underserved patients?

Holding health plans accountable to a more concrete measurement would contribute to the improvement of adequate networks; however, the improvement is contingent on regulatory monitoring and oversight being improved to enforce the standards, and does not guarantee a greater variety and distribution in provider type. Having identified that the supply of providers affects true adequacy of networks, we suggest that this method of optimization likely will not contribute to increased access to care for underserved populations because it will only improve regulation of networks and not increase the number of providers within a network.

**Area of Optimization: Metrics of Network Adequacy**

This method of optimization introduces a unit of measurement used by the California Office of Statewide Health Planning and Development called a Medical Service Study Area (MSSA). This method is championed by our client as a means of translating the Network Adequacy standard into increased access to care for low-income, medically underserved populations.

**What is the MSSA metric?**

MSSAs are sub-county or sub-city geographical units recognized by the U.S. Health Resources and Services Administration (HRSA) as a Rational Service Area (RSA) to determine...
“areas of unmet priority need for primary care family physicians”\textsuperscript{13} in response to legislative mandates. Each MSSA is comprised of one or more complete census tracts, and all population centers within the MSSA are within a thirty-minute maximum travel time to the largest population center. While MSSAs were developed in 1976, OSHPD updates the demographics and data on healthcare resources with decadal census data. This is important because it suggests that MSSAs most accurately reflect community demographics, which can be used to project current disparities and need. Consequently, OSHPD examines healthcare resources and needs within each MSSA in order to designate Health Professional Shortage Areas (HPSA) as defined by HRSA.\textsuperscript{14}

\textbf{Is it feasible to use MSSAs as the service area metric for Network Adequacy?}

The feasible options for geographic units used to define service areas in California include: census tracts, zip codes, and MSSAs. Given that data at the MSSA level are regularly updated to better reflect community demographics, and have been used by other regulatory agencies for the purpose of identifying areas’ needs for healthcare resources, they may be a better tool for how to define service areas. On the other hand, use of MSSAs as a new geographic unit would require an overhaul of the current system, which may or may not be feasible. The use of MSSAs would require the system to be redesigned by using, for example, a tiered system. MSSAs are small geographic units, and while the provider supply of urban MSSAs might be able to meet Network Adequacy standards, there would need to be additional standards for suburban and rural MSSAs that reflect the varied supply and demand for healthcare within those areas. Creating these tiers would be a time-consuming, expensive process, and while it would be a one-time cost to overhaul the current system, it might be politically and administratively infeasible.

\textsuperscript{13} The Song-Brown Act of 1973 chartered the creation of MSSAs.
\textsuperscript{14} Explanation on MSSAs available on http://gis.oshpd.ca.gov/atlas/topics/mssa
What are the benefits and tradeoffs of using MSSAs?

Since MSSAs have the potential to better reflect community demographics, assessing whether network adequacy standards are currently being met at the MSSA level could potentially inform the true adequacy of networks. However, these improvements would only be realized under improved regulatory conditions. For example, whether or not the unit of measurement is reflective of the demographic of the community, if physicians are 15 miles away, as current law permits, or are at capacity for their patient load, there will continue to be unmet demand for underserved populations without access to reliable transportation or a larger supply of in-network providers.

One tradeoff of using MSSAs as a metric is that it would require an overhaul of the current system, as mentioned earlier, and therefore require a large upfront cost to insurance companies and regulatory agencies. Additionally, given that MSSAs are much smaller units of measurement than the county or partial county level, regulatory agencies will need more manpower to survey the field and monitor more regions. Insurance companies will need to have networks with broader geographic ranges, which will increase the burden of compliance. While potentially a very helpful and effective method of optimization, the many tradeoffs to implementing the use of MSSAs could make it a less attractive option for policymakers and insurance companies and could lead to backlash.

Would using MSSAs help improve access to care?

Having defined that the supply of providers in California is an integral part of improving access to care, using MSSAs might help improve access in the long term by acting as a first step in identifying provider shortages. MSSAs as service areas and their respective plan networks could expose severe healthcare deserts in California previously obscured by the current metric and incentivize a push towards increasing supply. However, without addressing the service area
and provider supply issue in tandem, using MSSAs as the metric for measuring network adequacy would likely do little to close the access gap.

**AREA OF OPTIMIZATION: IMPROVED REGULATORY OVERSIGHT OF ECP**

**Is it feasible?**

To improve regulatory oversight of the ECP standard, Covered California might consider establishing a comprehensive monitoring and evaluation system to ensure that all QHPs are complying with the standard, and a clean-up of data to include up-to-date and accurate reporting. The Plan Management Division is still in the beginning stages of designing its compliance and monitoring system, and therefore implementing any changes might be more feasible, while increasing the staff requirements to implement these changes might be less feasible.

Similar to improving oversight for Network Adequacy, while improvements would be somewhat feasible for Covered California at the cost of increased staffing requirements for the new system, true compliance is contingent upon creating less ambiguous legal language, set metrics, and robust data sets. For example, the burden is currently on providers to report if they are not included on the list of ECPs published by Covered California, and the denominator for the service area used to certify compliance is unclear. Overall, Covered California has a window of opportunity to establish a strong regulatory system that focuses on the ECP standard as a legal requirement and determinant of access to care, not simply a certification metric.

---

15 The “denominator” refers to the measurement used in calculating if the required 15% of 340Bs is being met. For example, the denominator of a service area includes every ECP in that service area, while the “numerator” refers to the contracted ECPs within the service area of a network.
What are the Benefits and Tradeoffs?

Improved regulation of the ECP standard could be beneficial for the creation of more adequate networks, which in turn could help increase access to care if the standards truly translate to access. Additionally, more accurate data within the ECP provider list could potentially make it easier to capture the entire safety net provider population in California and ensure a better variation and distribution of ECPs in each health plan network. However, the amount of time required to maintain such a list creates an additional burden on Covered California as this burden is shifted away from providers. While stronger enforcement of penalties for non-compliance could potentially establish sufficient numbers of ECPs within networks, there will be an increased burden on insurance companies to comply with the standard.

Will Better Regulating the ECP Standard result in improved access to care for low-income medically underserved populations?

Improving regulation of the ECP standard could have an effect on the creation of more adequate networks; however, similar to improved regulation of network adequacy, it relies on an increase in supply if improved access is to be realized. There is merit in creating a streamline, efficient regulatory framework for Covered California, but without addressing the supply issue within the context of health plan networks, no additional gains would be made. For example, reflecting on the discussion of access issues in SPA 6, Figure 11, which shows Health Net’s network in Rating Regions 15 and 16 in Los Angeles, suggests that improved regulation would appear to have little effect on improving access to care. The minimum percentage of ECPs required in a network for certification is 15 percent, however, Health Net’s inclusion of ECPs is not clustered around the minimum but instead closer to 50 percent, suggesting that Covered

---

16 Health Net is one of the ten companies that sells QHPs on the State Based Exchange.
California’s oversight is unnecessary if “sufficient” is defined as 15 percent of all 340B providers, and increased oversight would not lead to improved network adequacy.

**Takeaway:** Almost 50% of the Primary Care ECPs in SPA 6 contract with Health Net’s Silver 70 Plans. ¹ This suggests two things, (1) Improved Regulatory Oversight of the standard would likely not result in improved network adequacy, and (2) Increasing the minimum percentage for “sufficiency” would likely have a marginal impact on improving access.

Therefore, improved regulation of the standard would have a potentially minimal impact on increasing patient access to ECPs unless the supply was able to meet demand.
AREA OF OPTIMIZATION: LEGAL LANGUAGE OF ESSENTIAL COMMUNITY PROVIDER STANDARDS

Is it feasible?

The current regulation of the ECP standard states that a “Contractor shall maintain a network that includes a sufficient geographic distribution of essential community providers that are available through Contractor to provide reasonable and timely access to Covered Services to low-income populations in each geographic region where Contractor’s QHPs provide services to Enrollees,” lxvii Essentially, assignation of a concrete number to the ECP standard is largely left to the discretion of Covered California, which chose to model its standard after the federal legal text. Therefore, including a more stringent definition of “sufficient” would be relatively simple to implement since the model contract with Covered California is updated every year. Covered California could issue a memo to insurance companies in anticipation of the model contract change for the upcoming year and subsequently implement the new legal language.

What are the benefits and tradeoffs?

Similar to the benefit of clarifying ambiguous legal language in the Network Adequacy standard, providing a more stringent definition of a “sufficient” number of ECPs has the potential to enable Covered California to better enforce the standard. Noncompliance would then be contingent on concrete numbers and would hinder the ability of insurance companies to claim adequacy based on a vague definition. On the other hand, the inclusion of more stringent standards reduces discretion on the part of Covered California to protect insurance companies from penalties for insufficient networks in a new marketplace.
Will better regulating the ECP Standard result in improved access to healthcare for low-income medically underserved patients?

The current ECP standard advocates for the inclusion of 15 percent of all 340B providers within a service area for the plan to be certified, and is the only specific metric that health plans must meet in terms of the ECP standard. This standard is viewed by Covered California as a success in capturing a wide range of providers in a given area. Redefining the percentage to define “sufficient” (for example, by increasing the 15 percent minimum) could potentially increase the network size, but this is contingent upon available variety and supply of providers in a geographic unit.

If the requirement included either a higher percentage or the “one ECP per category” required by the federal standard, it could potentially result in a marginal increase in access if those providers are already practicing within the geographic service area and become included in a plan’s network. The problem with this assumption is that there are demonstrated supply shortages in California, especially in low-income areas, and even if the standard required that QHPs contract with 100 percent of ECPs within a service area, access disparities would persist.

Using SPA 6 as a model, Figure 12 illustrates this claim. The map shows that within this small area there is a two-mile buffer area between healthcare facilities, suggesting that plans operating in SPA 6 can meet the “sufficient” number criteria of the ECP standard in terms of geographic proximity, even as this area in Los Angeles County is experiencing the most severe primary care physician shortage according to HRSA guidelines. Despite the fact that the ECP standard is in place to address low-income medically underserved population, the majority of SPA 6 has a patient-to-primary care physician ratio higher than 3500:1. The standard is not sufficient for solving the problem of the physician shortage in SPA 6, indicating that optimization of the legal

---

17 A facility’s service area is defined as area within 2 mile of each facility.
language would only have a marginal effect on improving access to care for low-income, medically underserved populations.

*Figure 12: Number of Patients per provider and available ECPs*

*Takeaway:* The areas in yellow show a two mile radius surrounding each ECP facility, and suggests that optimizing the legal language would likely not have large impact on improving access under the supply shortage conditions.

**Area of Optimization: Metrics of Essential Community Provider Standards**

**Is it feasible?**

Similar to using MSSAs for the service area in measuring network adequacy, the inclusion of a consistent measurement unit as the denominator for the inclusion of 15% of 340B providers in a service area would be feasible through a revision of the 2016 model contract. In fact, since the California ECP standard is outlined in the QHP model contract, it may be more
feasible than amending a regulation like the Network Adequacy standard. In addition, since Covered California’s Plan Management Division is relatively new, it may easier to make changes to the system and train staff accordingly.

**What are benefits and tradeoffs?**

Using MSSAs as the denominator for ECP contractual standards would be beneficial because MSSAs have the potential to better reflect demographics of an identified community and match these needs to available ECP supply. Though contingent upon having an adequate physician supply within each MSSA, using MSSAs as the service area metric for the ECP standard would potentially increase the number of providers in each network and perhaps have a marginal effect on increasing access to care for low-income, medically underserved populations.

With a clearly defined denominator, Covered California could better monitor whether ECP standards are being met. In addition, if DMHC and Covered California both use MSSAs as their metric, it could potentially improve coordination of regulatory oversight, and the two could monitor each other and collaborate to inform best practices.

As a tradeoff, insurance companies’ burden of compliance will increase if they are required to meet the ECP standard at the MSSA level which could lead to pushback and further lack of compliance. For example, currently, insurance companies can easily meet the standards by contracting with ECPs in wealthier areas if these areas are included in the same service area as underserved populations. Specifically, SPA 6, the area of Los Angeles with the most healthcare disparities, shares the same service area as Beverly Hills, a very wealthy area. If ECP standards are set at the MSSA level, insurance companies will have to search for providers in areas where they do not have established contracts and might lack the infrastructure to do so, possibly resulting in service interruptions for consumers.
Will using MSSAs as the service area for the ECP standard help increase access to care for low-income medically underserved populations?

The use of MSSAs as a service area for the ECP standard will likely have a minimal impact on increasing access to care for underserved populations. This is because the ECP standard is meant to ensure access to care for underserved populations, but does not account for the fact that low-income populations often lack an adequate supply of providers, including ECPs. Therefore, the supply of providers in these areas might able to meet the minimum contracting requirements of the ECP standard when measured at the MSSA level. However, meeting this minimum would not increase overall supply, therefore appearing to have a minimal effect in addressing the access gap for low-income, medically underserved populations.

Area of Optimization: Provider Expansion within Essential Community Provider Standards

Is it feasible?

Expansion of the ECP standard to include a broader variety and distribution of provider is feasible in that it could be achieved through a revision of the Covered California model contract. While the ECP standard is part of the federal code, California’s state-based discretion allows Covered California to make changes to its standards without federal red tape. Covered California could revise the 2016 model contract to include the federal requirement of “one ECP per category”\(^\text{18}\) to ensure that single service providers are included, and have a special addition that defines characteristics that certain private providers can meet to be listed as an ECP and included in more networks.\(^\text{ix}\) However, feasibility is contingent upon the capacity of Covered California to disseminate information of the change to patients, providers, and insurance

---

\(^{18}\) The “one per category” requirement is part of the federal safe harbor law for the ECP Standard and refers to the six major categories of ECPs: FQHCs, Ryan White Providers, Family Planning Providers, Indian Health Providers, and “other” ECP Providers.
companies, and increased costs to assemble a revised list of ECPs. From the point of view of interested stakeholders, many providers have voiced an interest in being listed as an ECP and would support the amendment.

**What are the benefits and tradeoffs?**

The benefit of including more specific minimum contractual requirements and additional types of providers is that the true population of ECPs will be better captured by health plan networks. However, two tradeoffs emerge. First, the inclusion of a “one per category” requirement might be difficult to achieve in rural service areas with small populations and a small supply of providers. Second, the inclusion of private providers dilutes the pool of public safety net providers with whom health plans currently contract. The reason that the inclusion of private providers is cut off beyond the Hi-Tech Incentive Program is that this program allows Covered California to track health outcomes and patient information more accurately to help understand the impact of ACA regulations in improving access to care. Covered California would have to increase monitoring if it included providers without these technological capabilities, and would perhaps need to adopt an additional standard to make sure that QHPs do not contract solely with private providers.

**Will Including More Types of Providers in the ECP Definition Improve Access to Care?**

Overall, the inclusion of more provider types and more specific contracting requirements can help optimize the ECP standard by improving the likelihood that a low-income, medically underserved patient has access to a provider who can meet their specific healthcare needs. However, the impact of these changes on increasing access to care is unclear, and likely low. The marginal impact on access from a sociocultural standpoint would be evident in that expansion of
provider types could increase the likelihood of a greater variety of culturally competent providers in QHP networks. Yet a measurable, significant improvement in access to care through the optimization of Network Adequacy and ECP standards appears to be contingent on interventions and incentives that increase the provider supply in California, for which this paper does not provide suggestions.
CHAPTER 8: RECOMMENDATIONS & CONCLUSIONS

RECOMMENDATIONS

Our client would like to see legislation within the ACA directed at increasing access to health care for underserved populations optimized. Our preliminary research revealed how improved ECP and Network Adequacy legislation may have the potential to increase access however, another possibility is that a lack of physician supply is the fundamental problem. The methods identified in Chapter 7 would make it easier for DMHC and Covered California to guarantee that all health plans are truly meeting the standards by holding insurance companies accountable, thus ensuring network adequacy. Moreover, accurate, up-to-date data will help both agency monitoring and customer navigation of networks. However, it is unclear whether this method would have an impact on closing the access gap due to the supply issue identified. Overall, streamlining regulatory oversight is necessary for general optimization of the system, and while it may narrow the gap, it will not close it.

Next, (1) clarifying the legal language by removing ambiguity and (2) expanding the variety of providers who qualify as ECPs may marginally optimize the provision, creating more clear guidelines for constructing health plan networks. To accomplish this, more research must be conducted to determine the best metrics, definitions, and additional provider categories to include, but the establishment of these standards will address the quality and adequacy of networks. However, while these changes will improve the composition of networks, the impact on access appears to be limited. This is because without actually increasing the supply available in these areas, network sizes will not increase; in other words, while variation improves, access remains the same, thus perpetuating the gap.
With regards to measuring adequacy, we have established that while DMHC and Covered California use a variety of methods to measure compliance based on zip codes, city and county lines, urban and rural distinctions, and rating regions, a more consistent, standard unit of measurement would make it easier for these regulatory agencies to verify compliance. In addition, standardized data will provide a more robust and representative metric to measure the effect of the current standards in generating access to determine how to improve legislation, and therefore access, in the future. Our client has proposed using the MSSA unit of measure as the standard denominator for a service area. This is because MSSAs were designed by taking into account the demographic and community-level differences that better define the needs of specific populations within each community. In addition, MSSAs are much smaller units of measurement, and using these geographic units as the denominator for network adequacy, there would be a larger potential effect on access than the methods discussed so far, because more providers would be available through a small number spread across a small distance than a small number spread across a large distance, which directly affects access.

We have provided a variety of methods that would help marginally improve the current systems serving underserved populations under the condition that the supply problem is addressed. On their own, these methods will have little effect on the improvement of access to the populations. While it is feasible to pursue these options, in the long term they would have little effect on the actual supply of providers, which is the crux of the problem. Therefore, we recommend that Dr. Baker focus his advocating efforts on methods to address physician shortages and increase supply. Only after provider supply is able to meet the growing demand generated by the ACA can optimization of the Network Adequacy and ECP Standards be realized.
LIMITATIONS

This study was limited to available public data and literature and key informant interviews. Due to the fact that the ACA is still relatively young, assessments and critiques of its implementation are rare and difficult to acquire in terms of data. Once ACA insurance claims data start to become available, a deeper, more intensive investigation can be done by taking patients’ opinions and concerns into account. Implementation of the ECP standard as a requirement for network adequacy is a relatively new regulation of which many providers are still not aware. Due to time constraints, we were also unable to reach out to many clinics and providers, and would consider it a limitation in our research. If we had access to insurance claims we would have been better able to address important analytic concerns including the cost from patient and provider perspectives, as well as specific patient access concerns and problems.

Another limitation of this study is that the patient to physician ratio is limited to primary care providers. Due to the lack of available data, we were unable to map out indicators that measure the capacity of each ECP facility, or the specific ECPs with whom QHPs have contracted. This would have given us a better idea of the distribution of specialty providers included in networks as well as raw numbers for clinics, and would have provided an “inside scoop” of where the most demand is in the market.

We were also limited in our predictions on the effect of optimization methods due to the fact that the necessary data regarding claims, agency development, and cost is still unavailable. Covered California is still relatively young and may not have had the manpower to implement such methods during its inception, but may be able to looking ahead. The fact that it is so young limited our ability to predict their future power and ability for regulation and implementation.
FURTHER RESEARCH

Looking ahead, there are multiple assessments that would be critical in determining the next steps in terms of helping to better serve underserved populations. One of the major studies that should be conducted is to dig deeper to capture the benefit and utilization of Essential Community Providers: What is the marginal social benefit of the ECP regulation? The projected goal of the ECP requirement is to improve access to health care for low-income medically underserved populations, however, the impact of ECPs in a post-ACA world has yet to surface. The uncertainty of the market and lack of significant insurance claims through Covered California at this point prohibits a robust analysis of the impact that ECPs have on closing the gap for low-income medically underserved populations.

Another important factor to look at once more cohesive ACA data becomes available is the cost associated with the implementation of the ECP and network adequacy standards: What is the cost associated with serving underserved populations? Cost of healthcare is a growing and constant concern in the United States and thus it’s important to consider in determining the benefits that these new policies provide against their costs.

A third topic to be considered would be the best methods of addressing the determined supply problem. A more in-depth assessment of best practices for increasing the supply of physicians in underserved population is required to determine the most efficient means of addressing this significant problem. Supply has been identified as the root of California’s healthcare barriers to underserved populations and should be further researched.
CONCLUSION

It is incredibly difficult to create an efficient, comprehensive, quality system with low political upset that adequately addresses the unmet health care needs of underserved populations by improving access. Maneuvering this developing system has created many challenges for Covered California in designing and implementing best practices and a comprehensive healthcare delivery system. However, our recommendation serves as a guide for strengthening the foundations of the ACA that still negatively affecting the delivery of health care to underserved populations. Our analysis has identified that the root cause of the inefficiencies that are preventing the Network Adequacy and ECP standards from increasing access to care is the inadequate supply of providers. While we have also identified other shortcomings in these two standards, addressing these additional shortcomings will not have a large impact on access as they are also contingent on reducing physician shortages in California. As the ACA becomes more clearly defined and more efficiently regulated it is important that the supply matches the demand in order to adequately help to improve long-term population health outcomes and reduce healthcare disparities. We are confident that our recommendation will help our client advocate to construct an essential foundation for improving care delivery for underserved populations not only in regards to statutory actions, but by truly improving access for these populations.
REFERENCES


x Covered California Qualified Health Plan Contract for 2014.
x Covered California Qualified Health Plan Contract for 2014.


xi Department of Public Health. Chapter Two: Access to Health Care. LA County Department of Public Health


xiv Department of Public Health. Chapter Two: Access to Health Care. LA County Department of Public Health

xvi Department of Public Health. Chapter Two: Access to Health Care. LA County Department of Public Health
xxviii Department of Public Health. Chapter Two: Access to Health Care. LA County Department of Public Health


California Code of Regulations, Title 28: Managed Health Care 1300.84.5b

https://archive.org/stream/ca.ccc.28/ca.ccc.28_djvu.txt

*California Code of Regulations, Title 28: Managed Health Care* 1300.51 P33.


Interview with DMHC licensing department representative. February 19, 2015.

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140SB964


Interview with Covered California Representative, March 16, 2015.

Code of Federal Regulations. Title 45: Essential Community Provider Standards


La County Department of Public Health. "Service Planning Areas in Los Angeles County.”

http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm

Park, Annie, Nancy Watson, and Lark Galloway-Gilliam. 2008. 'South Los Angeles Health Equity Scorecard'.


ix 'L.A.County Key Indicators Of Health Report'. 2009. [link]


x 'L.A.County Key Indicators Of Health Report'. 2009. [link]


xi 'L.A.County Key Indicators Of Health Report'. 2009. [link]


xii Critical Condition: Examining the Scope of Medical Services In South Los Angeles. 2015. Kurt Salmon Associates.

xiii Interview with DMHC licensing department representative. February 19, 2015.

xiv California Healthline. DMHC Launches Probe of Anthem Blue Shield Provider Networks. California Healthline, June 23, 2014. [link]


xvi Interview with DMHC Representative from the licensing department. February 19, 2015.


xviii Interview with Covered California Representative. March 15, 2015.


xx Interview with UCLA Fielding School of Public Health Faculty Member Dylan Roby, January 27, 2015.
The Affordable Care Act mandated that all qualified individuals must purchase health insurance or pay a tax penalty for remaining uninsured. In order to make health insurance plans available, the federal government set up a “Federally Facilitated Marketplace” through which states sell health plans that have been certified. The federal government gave states the power to establish their own marketplaces instead of using the federal marketplace, and these are called “State-Based Exchanges”. Covered California is the name of California’s Health Benefit Exchange. For this project we narrowed our scope to the “Silver 70” plans sold through Covered California which provide the best cost-sharing and premium assistance for underserved populations. Ten insurance companies sell these Silver 70 QHPs through Covered California: (1) Anthem Blue Cross of CA, (2) Blue Shield of California, (3) Chinese Community Health Plan, (4) Health Net, (5) Kaiser Permanente, (6) L.A. Care Health Plan, (7) Molina Healthcare, (8) Sharp HealthCare, (9) Valley Health Plan, and (10) Western Health Advantage.
APPENDIX B: QUALIFIED HEALTH PLAN METAL TIERs

Qualified Health Plans sold through Covered California fall under one of four “metal tiers”, including Bronze, Silver, Gold, and Platinum. They differ in premium cost, out-of-pocket cost, and total coverage. Bronze plans have the lowest premiums and Platinum plans have the highest, while Bronze plans have the lowest percentage of medical expenses covered, and Platinum plans the highest. For low-income medically underserved populations, it is most beneficial to purchase a Silver plan.
APPENDIX C: DESCRIPTION OF KEY INFORMANTS

Ahmed Al-Dulaimi: An employee in the Plan Management Division of Covered California, responsible for overseeing the certification of QHPs that meet the requirements of the model contract. He spoke with us extensively about the regulatory process for the ECP standard.

Teri Boughton: A former advisory member for the California State Assembly Committee on Health who spoke with us about the construction of Covered California’s 19 Rating Regions.

Richard Figueroa: A member of the California Endowment’s Senior Staff who spoke with us about rating regions, the establishment of the ECP standard in California, and directed us to Teri Boughton and Isaac Menashe.

Alison Mangiaracino: An employee in the Plan Management Division of Covered California who works with Ahmed Al-Dulaimi and spoke with us extensively about the regulatory process for the ECP standard.

Isaac Menashe: A Covered California employee and policy analyst who helped us navigate the Covered California and California Health Benefit Exchange websites to find qualitative data on the construction of the ECP standard.

Alina Salgonicoff: Vice President of the Kaiser Family Foundation and Director of the Women’s Health Policy Program. She spoke with us about the benefits of Title X Family Planning clinics and the need for their inclusion in the California ECP Standard.

Nancy Pheng Street: An employee in the licensing department of DMHC responsible for overseeing the certification of QHPs contingent on meeting all network adequacy standards. She spoke with us extensively about the regulatory process in certifying plans along network adequacy standards and helped us understand some of the biggest challenges in improving access to care.

Nancy Samra: A Plan Manager within the Plan Management Division of Covered California who spoke with us about the ECP standard and model contracts. Nancy recently left Covered California to being working at DMHC.

Laurie Sobel: A senior policy analyst at the Kaiser Family Foundation who specializes in Women’s Health Policy. She spoke with us about the benefits of Title X Family Planning clinics and the need for their inclusion in the ECP standard.
Rachel Tobey: Director of Health Services at the Jon Snow Institute in San Francisco, a public health management and consulting non-profit who spoke with us about the benefits of FQHCs, a type of ECP, in generating access to care for underserved populations.
APPENDIX D: SAMPLE INTERVIEW QUESTIONS

Questions Regarding Legal Language and Metrics:

1. The ECP law text provides a number of terms for which we have not been able to find clearly defined metrics. What are the metrics used by Covered California for the following terms to certify that a plan is meeting the standards:
   a. sufficient number:
   b. sufficient geographic distribution:
   c. reasonable and timely access:
   d. broad range:

2. We want to clarify the metrics of the ECP law safe harbor text. As we understand it, the federal regulation requires the following the three points listed below. We would like to clarify what the “one per category” metric is, as we thought that ‘categories’ referred to types like Indian Providers, Ryan White, Title X, etc.
   a. that 30% of all physicians who meet the ECP definition in a service area are included in each network
   b. that all Indian Providers in a service area are included in each network
   c. that “one ECP per category” in a service area are included in each network

3. We are aware that plans may disregard the safe harbor law if they can provide alternate standards. Are there any plans that are using an alternate standard? If so, what are the metrics of this alternate standard?

4. We know that California has an ECP requirement which states that plans must include 15% of all 340B providers in the plan’s service area, but that the law also eliminates single service providers.
   a. Does the single service provider designation refer to the “one ECP per category” requirement in the federal law?
   b. Why was this designation removed?
   c. What is the difference between an ECP and a 340B provider?
   d. Is the 15% 340B requirement included within the federal 30% requirement, or is it an additional 15%, meaning that 45% of physicians in a network meet the ECP definition? Or is it stand alone, so the California requirement is less than the federal requirement?

Questions Regarding Compliance and Monitoring:

1. Is Covered California the only regulatory agency that measures and monitors compliance with the ECP standard in Title 45? In speaking with a number of health plans, there was some confusion regarding the regulatory roles of DMHC, DHCS, CDI, and Covered California for the ECP regulation, and we wanted to clarify the roles of each.
2. How is compliance with the regulation monitored? Is monitoring on-going? (for example, every 6 months, once a year, etc)
3. Are all plans meeting the standards?
4. Do penalties exist for plans not meeting the standard? For example, if a plan is found to be non-compliant, are they automatically removed from the exchange or is there a greater focus on closer monitoring and corrective action?
5. Is there public record that plans are meeting the standards?

Questions Regarding Effectiveness and Benefits of ECPs:
1. What do you believe are the benefits of ECPs in providing care to underserved populations?
2. Do you think that including additional criteria that must be met within the definition would increase the supply of providers in networks, thereby reducing physician shortages? Would this create an additional burden for Covered California? How do you think insurance companies would respond?
3. How do reimbursements work for ECPs? We know that FQHCs receive a higher reimbursement rate, does this also hold for providers like 340Bs?
4. We understand that “service area” refers to the 19 rating regions (so, there are 19 service areas). If this is incorrect, what does a service area refer to? In addition, do you think that changing the metric for a service area to a smaller unit (for example, a Service Planning Area or Medical Service Study Area unit) would be feasible or beneficial for increasing the supply of ECPs? Would a smaller service area metric better demonstrate disparities?
APPENDIX E: DATA SET DESCRIPTIONS AND DATA ABSTRACTION TOOLS

United States Census Bureau - American Community Survey (ACS)\textsuperscript{lxxix}
- The ACS is an ongoing statistical survey administered the U.S. Census Bureau, and it provides socioeconomic and demographic information as well as geographic data.
- Our data of interest is the latest information on income (household/individual), insurance coverage, poverty status etc. by census tract.

State of California Office of Statewide Health Planning and Development (OSHPD) - Medical Service Study Areas (MSSA) Data\textsuperscript{lxxx}
- Medical Service Study Areas, Adopted by the California Healthcare Workforce Policy Commission in 2002, are sub-city and sub-county geographical units used to display physician, socioeconomic and demographic information.
- MSSAs are composed of complete census tracts and are updated every ten years.

Los Angeles County GIS Data Portal\textsuperscript{lxxxi}
- This data portal is the warehouse for all GIS data collected by Los Angeles County. We used the facilities data as a proxy to Medical Licensure Data to map the location of ECP and non-ECP facilities in SPA 6.

Qualified Health Plans (QHP) Regulations and Model Contracts\textsuperscript{lxxxii}
- QHP resources are available on the websites of the Center for Medicare and Medicaid Services and the California Health Benefit Exchange and each include a non-exhaustive database of Essential Community Providers (ECPs) as well as explanation of the dataset.

Data Abstraction Tools:

- Geographic Information Systems (GIS): A digital geographic mapping program. We set indicators for which the program extracted specific data from the public data sets that we used to map the geographic location of providers.

- STATA: A general-purpose statistical data program. We set indicators in the Covered California ECP list to drop duplicates.
## APPENDIX F: ESSENTIAL COMMUNITY PROVIDER STANDARD: FEDERAL VS. CALIFORNIA EXCHANGE

<table>
<thead>
<tr>
<th>Major ECP Categories</th>
<th>Federally Facilitated Marketplace</th>
<th>California State-Based Exchange</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. FQHCs</td>
<td></td>
<td>1. Hospital ECPs</td>
</tr>
<tr>
<td>2. Ryan White Providers</td>
<td></td>
<td>340B hospitals</td>
</tr>
<tr>
<td>3. Family Planning Providers</td>
<td></td>
<td>DSH hospitals</td>
</tr>
<tr>
<td>4. Indian Health Providers</td>
<td></td>
<td>Children’s hospitals</td>
</tr>
<tr>
<td>5. Hospitals</td>
<td></td>
<td>County hospitals</td>
</tr>
<tr>
<td>6. Other ECP Providers</td>
<td></td>
<td>2. Non-hospital ECPs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>340B Providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FQHCs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community Clinics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Free Clinics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tribal and Urban Clinics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Hi-Tech Incentive Providers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Minimum Contracting Requirements</th>
<th>Federally Facilitated Marketplace</th>
<th>California State-Based Exchange</th>
</tr>
</thead>
<tbody>
<tr>
<td>30% of the total number of ECPs in each plan’s service area</td>
<td>15% of the total number of 340B entities per applicable geographic region (service area or Rating Region)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Types of ECPs required</th>
<th>Federally Facilitated Marketplace</th>
<th>California State-Based Exchange</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Indian Health Providers AND one of each ECP type per category</td>
<td>At least one essential community provider hospital per region AND a minimum proportion of QHP network overlap.</td>
<td></td>
</tr>
</tbody>
</table>
In order to determine whether the ECP list from Covered California had any double-counting, we checked for duplicates through all variables on the list:

```
use "~/Applications/Personal/UCLA Quarter 5/APP/duplicate_check.dta"
```

```
tab type

<table>
<thead>
<tr>
<th>type</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>high tech</td>
<td>1,862</td>
<td>76.88</td>
<td>76.88</td>
</tr>
<tr>
<td>hospital</td>
<td>55</td>
<td>2.27</td>
<td>79.15</td>
</tr>
<tr>
<td>non hospital</td>
<td>505</td>
<td>20.85</td>
<td>100.00</td>
</tr>
</tbody>
</table>
```

```
duplicates drop
```

Duplicates in terms of all variables

{1190 observations deleted}

```
tab type

<table>
<thead>
<tr>
<th>type</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>high tech</td>
<td>790</td>
<td>64.12</td>
<td>64.12</td>
</tr>
<tr>
<td>hospital</td>
<td>54</td>
<td>4.38</td>
<td>68.51</td>
</tr>
<tr>
<td>non hospital</td>
<td>388</td>
<td>31.49</td>
<td>100.00</td>
</tr>
</tbody>
</table>
```

Total | 1,232 | 100.00 |
APPENDIX H: LEGAL TEXT FOR NETWORK ADEQUACY AND ESSENTIAL COMMUNITY PROVIDER STANDARDS WITHIN TITLE 45, THE PUBLIC WELFARE SECTION OF THE CODE OF FEDERAL REGULATIONS

“§156.230 Network adequacy standards.

“(a) General requirement. A QHP issuer must ensure that the provider network of each of its QHPs, as available to all enrollees, meets the following standards—

(1) Includes essential community providers in accordance with §156.235;
(2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and,
(3) Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act.

(b) Access to provider directory. A QHP issuer must make its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from the Exchange and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients.”

“§156.235 Essential community providers.

(a) General requirement. (1) A QHP issuer 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 for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

(2) A QHP issuer that provides a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group may instead comply with the alternate standard described in paragraph (b) of this section.

(3) Nothing in this requirement shall be construed to require any QHP to provide coverage for any specific medical procedure provided by the essential community provider.

(b) Alternate standard. A QHP issuer described in paragraph (a)(2) of this section must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.
(c) **Definition.** Essential community providers are providers that serve predominantly low-income, medically underserved individuals, including providers that meet the criteria of paragraph (c)(1) or (2) of this section, and providers that met the criteria under paragraph (c)(1) or (2) of this section on the publication date of this regulation unless the provider lost its status under paragraph (c)(1) or (2) of this section thereafter as a result of violating Federal law:

1. **Health care providers defined in section 340B(a)(4) of the PHS Act; and**
2. **Providers described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Public Law 111-8.**

(d) **Payment rates.** Nothing in paragraph (a) of this section shall be construed to require a QHP issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer.

(e) **Payment of federally-qualified health centers.** If an item or service covered by a QHP is provided by a federally-qualified health center (as defined in section 1905(l)(2)(B) of the Act) to an enrollee of a QHP, the QHP issuer must pay the federally-qualified health center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Act for such item or service. Nothing in this paragraph (e) would preclude a QHP issuer and federally-qualified health center from mutually agreeing upon payment rates other than those that would have been paid to the center under section 1902(bb) of the Act, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer indicated in paragraph (d) of this section."}$^\text{lxxiv}$
APPENDIX REFERENCES


