Local Health Departments as Essential Community Providers for Health Benefits Exchange Plans

The Affordable Care Act requires health plans' networks to include "essential community providers" (ECPs). Local health departments (LHDs) can be ECPs, typically for tuberculosis and sexually transmitted disease–related services or family planning. An ECP status may be controversial if it jeopardizes core population health services or competes with community partners. Some LHDs already bill for ECP services, but independent billing functions could exceed projected revenue. Thus, LHDs may wish to investigate contractual arrangements as alternatives to billing multiple issuers. (*Am J Public Health.* 2014; 104:e12–e14. doi:10.2105/AJPH.2013.301830)

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THE AFFORDABLE CARE ACT requires health plan issuers to include some essential community providers (ECPs) in their networks to qualify for participation in health benefit exchanges. Essential community providers are entities that help meet the needs of historically underserved areas and populations[1]; the classification includes federally qualified health centers, critical access hospitals, Ryan White grantees for HIV/AIDS services, and entities that provide services related to tuberculosis and sexually transmitted diseases (STDs), among others. Qualified health plans are required to contract with at least 20% of the ECPs in their service areas and with at least 1 in each service category, or document that doing so is not feasible.[2] The rationale for requiring inclusion of ECPs is to ensure continuity of service for newly insured individuals who had received services from ECPs, and to support the health care safety net after Affordable Care Act implementation increases access to third-party coverage.[2] The following brief review points to opportunities, challenges, and controversies that the ECP option raises for local health departments (LHDs).

ROLE AND IDENTITY OF ESSENTIAL COMMUNITY PROVIDERS

On March 26, 2013, the Centers for Medicare and Medicaid Services issued a "nonexhaustive" list of more than 17 000 ECPs with which qualified health plans could contract.[2] In general, the list includes providers that participate in 1 of 2 types of prescription drug support programs defined in the Public Health Service Act.[3,4] The accompanying narrative emphasizes that the range of eligible ECPs goes beyond the ECP rosters. Local health departments feature prominently on the ECP list, particularly for family planning, STD screening and treatment, and tuberculosis-related services. An influential 2012 Institute of Medicine report recommended that LHDs move away from direct provision of clinical care,[5] yet some ECP services may fall outside the range of care envisioned by this recommendation.

Nearly all states' listings include at least 1 LHD (Table 1), and the nonexhaustive nature of the list implies that other LHDs can be eligible providers. Thus, ECP status is a broad nationwide opportunity for LHDs to broaden their fiscal base. As with recent efforts to increase billing for vaccination services,[6,7] the opportunity to contract with qualified health plans warrants careful assessment.

In an era of shrinking funding for core public health services, it is likely that some LHDs will welcome the opportunity for ECP status and a new revenue stream. The LHDs that already participate in health plans and have established procedures for billing and collections are best positioned to become exchange plan ECPs. However, the prospect of billing for LHD core services raises some serious concerns.

CONSISTENCY WITH AGENCY MISSION AND POLICY

For LHDs contemplating participation as ECPs, one threshold question is whether ECP participation is consistent with the broader direction of public health agency development, both locally and nationwide, as reflected in the Institute of Medicine recommendation.[5] The ECP service category for which the issue of agency service provision is most likely to arise is family planning, which is offered in most areas by a broad range of community-based organizations in addition to LHDs. The 3 activities most commonly listed in the EHP roster for LHDs—screening and treatment of tuberculosis and STDs, and family planning—are also among the services LHDs offer most frequently. The 2010 National Association of County and City Health Officials (NACCHO) Profile Survey reports that most respondent LHDs offer tuberculosis screening (85%) and treatment (75%; Figure 7.1 of the NACCHO Survey),[8] and that STD screening (64%) and treatment (59%) are also very common, as are family planning services (55%; Figures 7.4, 7.5, and 7.6 of the NACCHO Survey).[8]

The state-specific ECP data[2] demonstrate that state public health systems vary considerably in the degree to which they rely on community partners for the provision of these services. Historically, tuberculosis and STD services have been provided at no

TABLE 1—Total and Unduplicated Local or State Health Department Listings in Essential Community Provider Roster, by State

State	Total, No.	Unduplicated, No.
AK	4	4
AL	83	70
AR	88	76
AZ	30	14
CA	74	49
CO	48	23
CT	1	1
DE	25	24
FL	116	65
GA	219	186
HI	3	1
IA	10	10
ID	39	8
IL	109	93
IN	8	5
KS	66	60
KY	153	139
LA	62	56
MA	3	3
MD	29	33
ME	5	2
MI	88	39
MN	3	3
MO	79	76
MS	97	83
MT	3	3
NC	118	96
ND	10	7
NE	2	2
NH	1	1
NJ	6	4
NM	44	43
NV	9	4
NY	64	51
OH	54	53
OK	90	69
OR	40	29
PA	11	10
RI	1	1
SC	69	50
SD	31	6

Continued

charge because of the shared understanding that the community benefits when affected individuals have barrier-free access to care. Billing for such services could be at cross-purposes with program goals if it inhibits access and thus must be sensitive to individual concerns. The LHDs will make these determinations based in part on their own communities' service mixes.

LOCAL HEALTH AGENCY BILLING AND RESOURCES

The Centers for Disease Control and Prevention Billables Project, which addressed billing for immunization services, grappled with challenges similar to those confronting LHDs in the ECP context. First, the general principle articulated in support of billing for vaccinations also applies with regard to tuberculosis, STD, and other typical LHD services: to ensure optimal use of federal funds, services provided to fully insured individuals should be billed to the individual's insurance carrier.[6] If an LHD uses federal grant funds when other funding sources are available, it may divert resources from those in greatest need. The insurance premium that individuals and their employers have already paid to their carriers (or included in their budget for self-insured employers) includes vaccination coverage. Thus, ethical principles of equity and stewardship support billing.[6] Several reports from Billables Project participants and other relevant materials can be found at the NACCHO Toolbox Web site under the heading "Billing for Clinical Services."[7]

Second, despite the arguments in favor of ECP participation, it is clear that, as with vaccination billing, careful analysis and preparation is necessary to determine whether ECP participation is feasible or advisable. Analyses from the Billables Project suggest that factors to consider include

- Payer mix and service coverage among those served by the LHD,
- Resources available to support the significant cost of billing third parties,
- Third-party credentialing and participating requirements, and
- State coverage requirements and their applicability.[7]

In addition to this common ground, some states have a statutory prohibition against charging patients for STD services, which could be interpreted as forbidding billing even if the patient incurs no out-of-pocket cost.[7] This issue, which again points to the need for barrier-free access, may be resolved by requesting a state attorney general's opinion that billing a third-party carrier does not violate applicable state law because patients themselves are not charged.

States took a variety of approaches to implementation of Billables Project findings, including the preparation of manuals in Iowa, Washington, and Georgia,[6] and consultation services from the state public health agency to LHDs in Ohio and New York.[9,10] In New York, where some LHDs had extensive experience in billing for specific services, a detailed report was prepared by a consulting group that covered such complex topics as revenue cycle management, information systems requirements, workforce capacity, and contractual requirements.[9] All the considerations covered in these analyses are relevant to LHDs considering ECP status with qualified health plans.

MEMORANDA OF AGREEMENT AS BILLING ALTERNATIVE

An alternative to billing is the use of contractual documents such as memoranda of agreement (MOAs) or understanding that specify the terms and conditions of health plans' relationships with LHDs. Such MOAs have been used for the past 2 decades to support LHD services to Medicaid managed care plans.[11] Typically, they enumerate covered services and reimbursement terms on the basis of the anticipated number of plan members requiring services. Although less flexible than billing, MOAs do not require as much administrative infrastructure. They thus would appear to lend themselves to arrangements between health plans and LHDs that do not provide ECP services at a volume that would support development of billing capacity, or that find billing poses undue risk to the populations they serve.

Model MOAs could be developed by state public health agencies and national organizations such as NACCHO and Association for State and Territorial Health Officials for adaptation to local needs and circumstances. These MOAs would achieve the goal of resource stewardship without requiring LHDs to take on the complex challenges of commercial carrier billing.

CONCLUSIONS

Essential community provider status could bring new revenue to LHDs that provide unique services to their communities in the categories covered by ECP listings. For LHDs that have experience billing commercial insurance carriers, the move to ECP status would appear to be a logical extension of existing

TABLE 1—*Continued*

TN	102	89
TX	32	19
UT	13	13
VA	122	38
VT	3	1
WA	55	38
WI	19	19
WV	52	48
WY	12	9

administrative and clinical practices. The LHDs that participate in the Centers for Disease Control and Prevention Billables Project may also find that processes developed for immunization billing can be extended to, for example, tuberculosis and STD services. Those LHDs that lack the experience or capacity to bill commercial carriers for ECP services may be able to use MOAs as the basis for ECP reimbursement, following the well-established models in use with Medicaid managed care organizations. In the current environment of grave fiscal stress, LHDs are likely to give the opportunity for ECP revenue careful consideration in the context of their agency's core mission and available resources. ■

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