5b. Questions and Responses

Questions	Responses
1) Adequacy determination: is it based on presence of provider, if currently accepting patients	Not asked whether they are accepting new patients
2) Is there a way to evaluate eligible but not enrolled?	Don't believe there's a DOI # = Governor + Exchange post #s but historically it's not given out.
3) Meeting Adequacy Standards – time OR distance?	Yes "OR" – as long as one passes (based on 2017)
4) We need to be careful making assumptions that Telehealth services can cover specialties; Still not be able to ensure HIPAA standards are met by using laptop/home internet	The data presented do not include Telehealth services; under statute they will have access.
5) Will ECP list change much?	See some improvement but not certain.
6) ECP list has not reflected accurate information	Based on accuracy of submitters; Will notify contact @ CMS
7) Does ACA Count ECP as legal entities or separate sites?	Make good faith effort to sign up 30% by county – but would be all locations.
8) Process when identified a "fail"? Formal? Adhoc? a) Formal Webinar b) Encourage contact or plan if available.	Go to provider; What is your access plan? Can't make providers go to an area Would provide list + seen they contact where insured go.
9) Requirement to achieve adequacy?	First Step: Yes, if no providers we don't want to diminish /stop them providing a plan. We step in after we find a deficiency – we put it on carrier to send templates; insured it meets; we are a backstop.
10) Why have a standard that puts DOI in position of finding solution vs. provider being obligated to notify about not meeting standards.	
11) How do we get to where problem is so we can better reflect reality + advise	We have a formal process; not just a phone call; in counties like Esmeralda they don't have adequate providers. Variations are in place to insure health care is available. Still have access. Annual certification process – rate review (late spring); back + forth; additional regulation; Enforcement is outside Council scope, but there is a formal process and provisions for that.
12) What data is used by DOI to determine adequacy?	What providers share/report contracted providers carriers tell us are in network.
13) Providers are counted more than once when they have more than one location.	We can look into it.
14) Would it be more an issue for urban? Specialties?	Not necessarily urban or specialty. We take steps to remove duplications.
15) Where do you get data from?	Carrier data – Actual is based off carrier

	submissions – will look at count #s for accuracy
16) Could telemedicine be a factor?	No
17) When we submit geo access we submit from where – could they live in other counties?	Not for actual but for adequate.
18) How are providers counted? # providers within county double X # locations across county separate	In county multiple locations will duplicate; across counties = counted /x for each.
19) Autism providers by specialist by county. Is that # that provides autism services?	Only # for psychologists – not all provide autism services.
20) Are providers list provided to you? List given by statute/created? Is it underrepresented given providers listed?	Declaration document requires they list all providers, but not necessary for specific scenarios. Defined by AB 6.