



Suggested State Legislative Language re: FQHC Contracting and Payment Provisions in Health Insurance Exchanges

The paragraphs below are in response to the requests that NACHC has received from PCAs for “model” Health Insurance Exchange (HIE) language relating to plans contracting with and payment to health centers. Obviously, so much of the way you will want to word these provisions depends on the other provisions in the state legislation relating to HIEs –so this is really not “model legislation” but simply suggested language and/or references you might want to get into relevant state law. If and when your state develops HIE draft language, or regulations or the like, NACHC will try to be of assistance in helping you work out the most useful language on the FQHC contracting and payment issues.

Please note that you would be using only **one** of the three paragraphs below. Ex.1 is the best and most straightforward but also raises the most “red flags” regarding contracting and paying FQHCs. Ex. 2 is a little less direct and Ex. 3 is the least direct but specific enough to insure that the entities benefitting from this language are FQHCs.

Ex. 1 The Health Benefit Exchange shall require that each health plan, as a condition of participation in such Exchange, shall (1) offer to each Federally-qualified health center (as defined in Section 1905(l)(2)(B) of the Social Security Act (42 USC 1396d(l)(2)(B)) providing services in geographic areas served by the plan, the opportunity to contract with such plan to provide to the plan’s enrollees all ambulatory services that are covered by the plan that the center offers to provide and (2) reimburse each such center for such services as provided in Section 1302(g) of the Patient Protection and Affordable Care Act (Publ. L. 111-148) as added by Section 10104(b)(2) of such Act.

Ex. 2 The Health Benefit Exchange shall require that each health plan, as a condition of participation in such Exchange, shall (1) offer to each provider that receives funding under section 330 of the federal Public Health Service Act (or that meets all of the requirements to receive funding under section 330 of such Act) and that provides services in the geographic area served by the plan, the opportunity to contract with such plan to provide to the plan’s enrollees all ambulatory services covered by the plan that the provider offers to provide and (2) reimburse each such provider for such services as provided in Section 1302(g) of the Patient Protection and Affordable Care Act (Publ. L. 111-148) as added by Section 10104(b)(2) of such Act.

Ex. 3 The Health Benefit Exchange shall require that each health plan, as a condition of participation in such Exchange, shall (1) offer to each essential community provider that is a covered entity listed in Section 340B (a)(4)(A) of the Public Health Service Act and that provides services in the geographic area served by the plan, the opportunity to contract with such plan to provide to the plan’s enrollees all of the ambulatory services covered by the plan that the provider offers to provide and (2) reimburse each such entity for such services as provided in Section 1302(g) of the Patient Protection and Affordable Care Act (Publ. L.111-148) as added by Section 10104(b)(2) of such Act.