



NATIONAL ASSOCIATION OF
Community Health Centers



Final Medicaid and Exchange Regulations
Implications for Federally Qualified
Health Centers

April 2012

Final Medicaid and Exchange Regulations

Implications for Federally Qualified Health Centers

What's Covered

- *A review of current Medicaid FQHC payment provisions*
- *New regulations on Medicaid Eligibility and the impact on health centers and their patients*
- *New regulations on the Establishment of Exchanges and the impact on health centers and their payment under these new Exchanges*

Introduction

In late March 2012, HHS published both final and interim final rules implementing key provisions of the Affordable Care Act (ACA) regarding Medicaid eligibility expansion and the establishment of Exchanges and Qualified Health Plans (QHP).¹ This issue brief highlights several provisions of both sets of rules that relate specifically to FQHC participation, services and payment. There are, of course, many other provisions in these rules that will impact FQHCs and their patients directly and indirectly, and in this paper we have highlighted some of these rules relating to Medicaid eligibility. More important, a number of articles have already been published providing analyses of both sets of rules and no doubt many more will be published in the upcoming months.²

A number of these Medicaid (and certain CHIP) rules and Exchange/QHPs rules issued by HHS are interim final rules for which HHS welcomes comments before they are finalized. **The deadline for public comment on the interim final Medicaid regulations is May 7, 2012. The comment deadline on the interim final Exchange/QHP rules is May 11, 2012.** NACHC is reviewing these interim final rules and will submit comments on those that appear to be of particular importance to FQHCs and their patients

To some degree the Exchange/QHP regulations that were finalized by HHS are of more immediate concern to FQHCs and PCAs than the final Medicaid rules since the former are effective on May 29, 2012 while the Medicaid rules take effect on January 1, 2014. More important, many states are currently developing their Exchange/QHP policies either through state legislation, regulations or other processes. Also, as will be clear in the following sections of this paper, assurances of FQHC participation, services and payment in the Exchange/QHP programs are not as secure as they appear to be in the Medicaid

¹ In this article, the term Affordable Care Act or ACA refers both to the Patient Protection and Affordable Care Act of 2010 (Pub. L 111-148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L 111-15). The Medicaid eligibility rules were published in the Federal Register on March 23, 2012 (77 Fed. Reg. 17144 et seq) and the Exchange/QHP rules on March 27, 2012 (77 Fed. Reg. 18310 et seq.).

² There are several articles about the implementation of both the Medicaid expansion and the creation of the Exchanges. Here are just a few we have found helpful: [Health Reform GPS' Update: Exchanges Establishment and Eligibility Final Rule](#), [Health Reform GPS' Update: Highlights from the Final ACA Medicaid Eligibility Regulations](#), and Manatt Health Solutions' [Overview of the Final Medicaid Eligibility Rule](#)

expansion program. Nonetheless, in this paper, we first cover the Medicaid expansion issues as we believe it is important to review the FQHC protections and gaps in Medicaid in order for FQHCs and PCAs to better appreciate the potential barriers that FQHCs may face in the state Exchange/QHPs programs and how these barriers might be overcome.

FQHCs and the Medicaid Expansion in the ACA

FQHC service and payment requirements in Medicaid law

The Medicaid statute contains a number of critical requirements relating to FQHCs services and payment that were in the Medicaid statute prior to the passage of the ACA and should apply to FQHC services provided to the new group of Medicaid beneficiaries established under the ACA. Specifically, federal Medicaid law (1) establishes the services of an FQHC as a required Medicaid service, (2) defines these services to include rural health clinic services as defined in the Medicare statute plus any ambulatory service included in the state Medicaid plan, and (3) requires state Medicaid agencies to reimburse FQHCs for these services based on a prospective payment system (PPS) per visit rate as provided in Section 1902(bb) or through an alternative payment methodology (APM) that the FQHC agrees to and which will result in the FQHC being paid no less than it would be paid under PPS.³

In addition, the Medicaid statute provides that when an FQHC contracts with a managed care organization (MCO) to serve Medicaid recipients enrolled in the MCO, the MCO must pay the FQHC no less than it would pay other providers for similar services. Additionally, the State Medicaid agency is required to reimburse the FQHC the difference between the payments the FQHC received from the MCO for services to the MCO's Medicaid enrollees and the amount the FQHC should be paid for such services under PPS/APM.⁴ The purpose of this latter requirement, the so-called "wrap-around" payment from the state to the FQHC, is to insure that an FQHC continues to receive its full PPS (or APM) payment from the state rather than the MCO. This ensures that the MCO is not disincentivized from contracting with an FQHC by having to pay a higher payment to FQHCs than it would pay other providers.

As a result of these FQHC provisions in the Medicaid statute, MCOs must contract with FQHCs because FQHCs services are a required Medicaid service and FQHCs must be paid PPS/APM for these services by way of the MCO payment and the state Medicaid wrap-around.⁵

FQHC services and payment for Medicaid beneficiaries newly eligible under the ACA

The Medicaid expansion provisions in the ACA require for the first time that beginning on January 1, 2014, state Medicaid agencies must cover individuals age 19 through 65 who have household income at or below 133% of the federal poverty line (FPL).⁶ This provision in the Medicaid statute is expected to increase the number of Medicaid beneficiaries being served by FQHCs from 7.5 million in 2010 to as many as 18 million in 2015. **This provision of the ACA requiring coverage of singles adults, and related Medicaid provisions in the ACA, does not revise the FQHC payment provisions in the Medicaid statute,**

³ Sections 1902(a)(10)(A), 1905(a)(2)(C), and 1902(bb) of the Social Security Act (SSA)

⁴ Sections 1903(m)(2)(A)(ix) and 1902(bb)(5) of the SSA

⁵ MCOs need not contract with every FQHC in the service area, but must contract with at least one FQHC so as to assure availability of FQHC services to Medicaid managed care enrollees

⁶ Section 1902(a)(10)(A)(i)(VIII) of the SSA as amended by Section 2001(a) of the ACA

consequently implementation of these statutory requirements in 2014 should not affect FQHC PPS/APM payment requirements.

The final Medicaid regulations issued by HHS/CMS in March 2012 (effective January 1, 2014), and the preamble to these regulations, focus primarily on rules relating to determining eligibility such as: determining income, timeliness standards, citizenship and residency requirements, reducing barriers to enrollment and eligibility determinations and redeterminations, and coordinating and streamlining the eligibility and enrollment process between Medicaid, CHIP and state Exchanges.⁷ **These rules, like the ACA itself, do not directly revise or otherwise address FQHC service and payment issues. Consequently, the FQHC protections mentioned in the previous paragraphs appear to remain in effect, including those that concern FQHC services, contracting, and payment in state Medicaid managed care programs.**

CMS has yet to promulgate proposed or final rules concerning the range of services that the new Medicaid eligible population will be eligible to receive as Medicaid recipients. There is a provision in the ACA that appears to allow for a more limited range of benefits (“benchmark” or “benchmark equivalent” coverage) for this population.⁸ We believe, however, that the current FQHC protections in the law, specifically the provisions that require FQHC services (and FQHC payment) in these “benchmark” or “benchmark equivalent” plans, will apply under this new provision.⁹ We assume that CMS will soon focus on proposed and final rules relating to required services for this newly eligible population and we will look to see if and how they deal with FQHC services for this new expansion population—and, of course, we will seek to assure that FQHCs are allowed to provide, and be reimbursed for, the full range of FQHC services for this new Medicaid eligible population.

Other provisions of the ACA-related Medicaid final rules of particular interest to FQHCs

The final rules promulgated by CMS contain a number of requirements that are of particular interest to FQHCs because they should simplify, improve and expedite Medicaid eligibility determination and re-certification processes and therefore, should reduce substantially many of the barriers health center patients face in applying for and retaining Medicaid coverage. Listed below is a brief summary of just a few of these rules¹⁰

- The State Medicaid agency must accept an application and any documentation required to establish eligibility via internet Web site, by telephone, via mail, in person, and through “other commonly available electronic means.”¹¹
- The application must be a “single streamlined application for all insurance affordability programs” developed by HHS (Medicaid, CHIP, Exchange/QHP, Basic Health Plan) or an alternative application that is “no more burdensome on the applicant” than the one developed by HHS.¹²

⁷ 77 Fed. Reg. 17144 et seq (March 23, 2012)

⁸ Section 1902(k)(1) of the SSA as amended by Section 2001(a)(2)(A) of the ACA

⁹ Section 1937(b)(4) of the SSA

¹⁰ A extended description of a number of these new rules can be found in Health Reform GPS’ “Update: Highlights from the Final ACA Medicaid Eligibility Regulations” by Sara Rosenbaum

¹¹ 42 CFR 435.907(a)

¹² 42 CFR 435.907 (b)

- The agency may not require an in-person interview as part of the application process for determination of eligibility based on Modified Adjusted Gross Income (MAGI).¹³
- As a general rule, an individual's eligibility must be subject to renewal no more frequently than once every 12 months.¹⁴
- Redetermination of eligibility must be made without requiring information from an individual if it can be done "based on reliable information contained in the individual's account or other more current information available to the agency" and the agency cannot require an in-person interview as part of the renewal process.¹⁵
- Financial eligibility must be based on current monthly household income and family size, but for those determined financially eligible per MAGI, the state agency may elect to base financial eligibility either on "current monthly household income and family size or income based on **projected annual household income** and family size for the remainder of the current calendar year."¹⁶
- State of residence for an individual age 21 or over "is the State where the individual is living and (1) intends to reside, **including without a fixed address**; or (2) has entered the State with a job commitment or seeking employment (**whether or not currently employed**)."¹⁷ For an individual under age 21, state of residence is where the individual resides including without a fixed address or the State of residency of the parent or caretaker.¹⁸
- A state agency may opt to verify state residency through self attestation or attestation by an adult who in the applicant's household, or if the applicant is a minor, from someone acting for the individual, without requiring further information (including documentation) from the individual.¹⁹

FQHC Participation and Payment in the Exchange Programs

With regard to payment and contracting with FQHCs, there are substantial differences between the statutory requirements in the Medicaid statute and the establishment of Exchange and Qualified Health Plan requirements in the ACA. To some degree, the final HHS Exchange/QHP rules reflect these differences, however we believe they fall short of both the requirements and the intent of the ACA with regard to FQHC participation in the Exchanges, and in at least one instance, need to be further clarified to assure appropriate implementation of statutory FQHC payment requirements.

¹³ 42 CFR 435.907(d). A major change in Medicaid policy, as required under ACA, is the creation of a new financial eligibility standard based on MAGI, which applies to the new category of single adults as well as to children, parents, caretakers and pregnant women

¹⁴ 42 CFR 435.916(a)(1)

¹⁵ 42 CFR 435.916(a)(2) and 435.916(a)(3)(iv)

¹⁶ 42 CFR 435.603(h)(2)

¹⁷ 42 CFR 35.403(h)(1)

¹⁸ 42 CFR .403(h)(2).

¹⁹ 42 CFR 435.956.(c) and 435.945(a)

FQHC services in the Exchange

Unlike the Medicaid statute, there is nothing in the ACA that defines FQHC services in an Exchange or that provides that FQHC services must be made available to enrollees in Qualified Health Plans (QHP) that are certified by an Exchange. The ACA requires, however that QHPs certified by Exchanges to serve Exchange enrollees must provide a package of Essential Health Benefits (EHB), that HHS is to define those EHBs, and that EHBs must include items and service in 10 benefits categories.²⁰ The ten EHB benefits categories required by the ACA include many services offered by FQHCs such as ambulatory patient services, maternity and newborn care, mental health and substance use disorder services including behavioral health treatment, prescription drugs, laboratory services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care.²¹

HHS has not yet proposed regulations relating to and defining EHBs; however HHS' Center for Consumer Information and Insurance Oversight (CCIIO) did issue an EHB "Bulletin" in mid-December 2011 outlining and seeking comments on its "intended regulatory approach." NACHC's [comments](#) in response to CCIIO's Bulletin stated, among other things, that HHS should promulgate regulations that provide for a nationwide minimum core of EHBs available through QHPs and that these EHBs should include services provided by FQHCs as those services are defined in Medicaid FQHC legislation.²²

QHPs contracting with FQHCs

The final rules issued by HHS in the Federal Register of March 27, 2012 establish, among other things, the minimum standards that health insurance issuers must meet if they want to participate in Exchanges and offer qualified health plans (QHPs) to individuals eligible to participate in the Exchange.²³ As already noted, unlike Medicaid, FQHC services are not a required service that QHPs must offer to Exchange enrollees. Moreover, there is not a provision in the ACA, or in the recently promulgated Exchange regulations, that requires Exchanges to require QHPs to contract with FQHCs to serve Exchange participants who are enrolled with a QHP. However, there are a number of provisions in the ACA and in these implementing regulations that should result in QHPs contracting with FQHCs.²⁴

One of these provisions is the requirement in the ACA that QHPs ensure that a sufficient number of providers be available to Exchanges participants.²⁵ HHS implements this requirement by establishing network adequacy standards that require that a "QHP issuer must ensure that the provider network of each of its QHPs . . . include essential community providers"²⁶ and maintains a network "that is sufficient in number and types of providers . . . to assure that all services will be accessible without unreasonable delay."²⁷ In the preamble or commentary to this rule, HHS states that it modified this final rule from its earlier proposed version to strengthen the network adequacy requirement by establishing "all services . . . without unreasonable delay" as the "baseline . . . against which network adequacy can be

²⁰ Sections 1301 and 1302 of the ACA

²¹ Section 1302(b) of the ACA

²² 1905(a)(2) (C) of the Social Security Act

²³ 77 Fed. Reg. 18310 et seq

²⁴ [NACHC's comments](#) on the proposed Exchange rules contain an extensive discussion and proposal that these ACA provisions can best be implemented by requiring QHPs to contract with FQHCs.

²⁵ Section 1311(c)(1)(B) of the ACA

²⁶ FQHCs qualify as essential community providers (see following page of this Issue Brief)

²⁷ 45 CFR 156.230 (a)

measured.”²⁸ HHS also notes that “nothing in the final rule limits an Exchange’s ability to establish more rigorous standards for network adequacy.”²⁹

This rule regarding network adequacy provides a good basis upon which PCAs and FQHCs can look to their Exchange to require that QHPs contract with FQHCs, and allows FQHCs to make the same case to QHPs so that they can comply with federal and Exchange provider adequacy rules.

The more specific requirements in the ACA and in the Exchange regulations regarding essential community providers (ECP) substantially strengthens the case for QHPs being required to contract with FQHCs. In this regard, the ACA provides that Exchanges:

shall require that to be certified a plan shall, at a minimum—

(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act...³⁰

Thus, Section 1311 of the ACA requires the Secretary to ensure, by regulation, that Exchanges only certify plans that include “essential community providers” that serve “predominantly low-income medically underserved individuals.” The health care providers referenced in this section of the ACA as potential ECPs are providers that qualify for discounted drugs under the Public Health Service Act’s Section 340B drug discount programs. FQHCs are one of those covered entities.

HHS’ final rule implementing the ECP provisions defines ECPs as providers that serve “predominantly low-income medically underserved individuals”, including 340B covered entities.³¹ It also provides that 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 Exchanges network adequacy standards”³²

Similar to its explanation of the final “network adequacy rule,” HHS explains in its commentary to the final ECP rule that it modified this rule from its earlier proposed version in order “to direct that each QHP’s network have a sufficient number and geographic distribution of [ECPs], where available, to ensure reasonable and timely access to a broad range of such providers for low-income medically needy individuals in the QHP’s service area, in accordance with the Exchange’s network adequacy standards.”³³ HHS also “emphasize[s] that Exchanges have the discretion to set higher more stringent standards with

²⁸ 77 Fed Reg., at 18419

²⁹ 77 Fed Reg., at 18419

³⁰ Section 1311(c)(1)(C) of ACA

³¹ 45 CFR 156.235(c)

³² 45 CFR 156.235(a)

³³ 77 Fed reg., at 18421

respect to essential community providers participation, including a standard that QHP issuers “offer a contract to any willing essential community provider.”³⁴

HHS also states in its commentary to this rule that while it believes the ACA provision of inclusion of ECPs in QHP provider networks “must translate into meaningful access to care for low-income and medically underserved populations,” the statute’s requirement regarding contracting with ECPs does not require a QHP “to cover any specific medical procedure.” However, HHS then concludes: “[w]e generally anticipate and expect issuers will contract with essential community providers for all services furnished by the providers that are otherwise covered by the QHP”³⁵

Thus, while the final Exchange rules do not mandate that QHPs contract with FQHCs, they are clear in requiring that QHPs ensure that Exchange participants living in medically underserved areas have adequate meaningful access to ECPs, and they would certainly allow Exchanges to require QHPs to contract with “any willing FQHC” to serve QHP enrollees. In addition, it seems clear that HHS expects QHPs to contract with ECPs for the full range of services offered by the ECP to the extent that those services are covered by the QHP. In short, these final rules will likely incentivize both Exchanges and QHPs to assure that FQHCs are contracted with by QHPs to serve Exchange participants in order to satisfy the “network adequacy” and “sufficient number of ECPs” requirements of these rules.

QHP payment to FQHCs for services to Exchange participants

The ACA contains a specific requirement regarding QHP payments to FQHCs for services provided to an Exchange participant enrolled with the QHP. Section 1302(g) of the ACA, as added by Section 10104 of the ACA, provides as follows:

If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 USC 1396d(l)(2)(B))[the Medicaid statute] to an enrollee of the plan, the offeror of the plan shall pay to the center for the items and services an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of such Act (42 USC 1396(bb))[Medicaid FQHC PPS/APM payment] for such item or service.

Thus, the ACA requires that FQHCs be paid by QHPs no less than what they would be paid by the state Medicaid agency for these services. Notably, this provision of the law does not limit this payment requirement to FQHCs that have contracted with the QHP to provide services to enrollees of the QHP. This provision, therefore, appears to require the Medicaid FQHC payment rate (either PPS or APM) by a QHP to a FQHC for services to an enrollee, regardless of the FQHC’s contracting status with the QHP. That is, the QHP must pay the FQHC payment rate to FQHCs that are considered both “in network” and “out of network.”

Another, more general, provision in the ACA that relates to contacting and payment by QHPs to ECPs has resulted in HHS diluting the FQHC payment mandate. Section 1311(c)(2) of the ACA provides that a QHP need not contract with an ECP that refuses to accept the “generally applicable rates of such a plan.” In the preamble to its proposed rule, HHS maintained that this payment provision conflicted with the FQHC payment requirement and stated that one of the options it was considering would be to allow

³⁴ 77 Fed Reg, at 18421

³⁵ 77 Fed Reg, at 18421

QHP issuers “to negotiate mutually agreed-upon payment rates with FQHCs as long as they are at least equal to the issuer’s generally applicable payment rates,” which HHS notes may be less than the FQHC’s Medicaid PPS rate.³⁶

Despite the clear FQHC payment requirement in the ACA and despite [comments](#) submitted by NACHC, PCAs and FQHCs opposing this proposal, HHS final Exchange rule specifically allows for the negotiated mutually agreed upon rates option. The final rule states:

If an item or service covered by a QHP is provided by a federally-qualified health center . . . 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 [the FQHC payment provisions of the Medicaid statute] for such item or service. **Nothing in this paragraph (e) would preclude a QHP issuer and a 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 rates of the issuer....**³⁷

This final rule, which would allow an FQHC to be paid less than PPS/APM as long as the payment rate is mutually agreed upon between the QHP issuer and the FQHC, would not in and of itself result in an FQHC being paid less than PPS/APM since any different rate must be “mutually agreed upon” and a FQHC could determine not to contract with a QHP for less than its PPS/APM. The problem is that in its final rule, HHS does not require Exchanges to contract with FQHCs, and (unless future final HHS rules regarding Essential Health Benefits state otherwise) FQHC services are not a required service that must be offered by a QHP. Consequently, the QHP issuer in negotiating with the FQHC could tell the FQHC that unless it accepts less than its PPS/APM rate; the QHP will not contract with the FQHC to serve its enrollees.

However, there are several provisions/requirements in the ACA and the final Exchanges rules, and in HHS’ commentary to the rules, that can assist PCAs and FQHCs in securing PPS/APM payment from QHPs issuers in contracting to serve their enrollees. For example, as already noted, the FQHC payment provision in the ACA and in the final rules do not distinguish between QHPs that have contracted with FQHCs and those that have not—the ACA simply requires that an QHP pay the FQHC an amount comparable to the FQHC’s Medicaid PPS/APM payment for services the FQHC provides to the QHP enrollee, and HHS’s final rules also require such a payment or, as a alternative, allow for a mutually agreed upon payment amount. Consequently, if a QHP enrollee goes out of network to an FQHC, the QHP must pay the PPS/APM amount to the FQHC unless the FQHC agrees to a different payment. There is no reason for an FQHC to agree to accept less than PPS/APM for services to out of plan QHP enrollees. Thus, the FQHC might be able to use this out-of plan payment requirement as a basis to negotiate a contract to serve QHP enrollees for full PPS/APM payment or for an amount that is less than PPS/APM but that is fair and genuinely agreeable to the FQHC. In other words, there should be an incentive for a QHP to contract with an FQHC as it would otherwise have to pay the FQHC a PPS/APM every time an enrollee went out of plan to the FQHC.

³⁶ 76 Fed Reg at 41900 (July 15, 2011)

³⁷ 45 CFR 156.235(e) (emphasis added)

The chances of successfully negotiating such a contract would, of course, be further enhanced if the Exchange's rules required QHPs to contract with any FQHC offering to contract with a QHP insurer. As already noted, the final HHS Exchange rules do not require Exchanges to do so, but the HHS commentary to the final rules makes clear that Exchanges can choose to require contracting with an "any willing ECP." Certainly a narrower mandate to contract with any willing FQHC would be acceptable to HHS as well.

Also, as discussed in the previous section of this paper, the "network adequacy" and "access to ECPs" requirements in HHS' final Exchanges rules and HHS' commentary relating to these rules, should strengthen the ability of an FQHC to negotiate a PPS/APM payment from QHP issuers, particularly if state Exchange rules and policies relating to certifying QHPs contain strong "network access" and "access to ECPs" requirements. FQHCs located in areas where there is a dearth of other ECPs will be in a particularly strong position to negotiate for a PPS/APM payment.

If you have questions or would like further information on the issues covered in the Issue Brief, please call or email Roger Schwartz (202-296-0158; rschwartz@nachc.org) or Susan Sumrell (202-997-5922; ssumrell@nachc.org) at NACHC.