

Qualified Health Plans & Health Centers: A Primer

QUALIFIED HEALTH PLANS AND ESSENTIAL COMMUNITY PROVIDERS

Qualified health plans (QHPs) are health plans that are certified to be sold in the Health Insurance Marketplace created by the Affordable Care Act (ACA). To be approved as a QHP, a plan must meet certain minimum requirements. One such requirement is to contract with a sufficient number and geographic distribution of “Essential Community Providers (ECPs),”¹ or providers serving low-income or medically underserved populations. Under current federal rules, QHPs sold in states where the federal government is running the Marketplace generally must:

- Contract with at least 30% of all available ECPs in their service area,
- Offer good faith contracts to all available Indian providers in the service area, and
- Offer good faith contracts to at least one of each type of six different categories of ECPs for each county in the service area.

States that are administering their own Marketplaces, either independently or in partnership with the federal government, may have ECP contracting requirements that are more extensive, but not less, than those for QHPs operating in Federally-Facilitated Marketplaces (FFMs.)

HEALTH CENTERS AS ESSENTIAL COMMUNITY PROVIDERS

Federally Qualified Health Centers (FQHCs) – which encompass Community, Migrant, Homeless, and Public Housing Health Centers – are one of the six categories of ECPs for which specific contracting requirements apply. QHPs are required to offer a contract to at least one FQHC in each county in their service area.

Many characteristics of the health center model demonstrate their inherent role as Essential Community Providers, making them important partners for QHPs seeking to serve low-income and medically underserved populations.

Health centers’ federally mandated model of care ensures that they function as ECPs. By law, health centers must meet numerous requirements, including but not limited to:

- Serve a federally-designated medically underserved area or a medically underserved population;
- Serve all individuals regardless of ability to pay;
- Charge no more than a “nominal fee” to uninsured and underinsured individuals with incomes below 100% FPL, and charge uninsured and underinsured individuals between 101% - 200% FPL based on a sliding fee scale; and
- Provide non-clinical enabling services to increase access to care, such as transportation, translation, and case management.

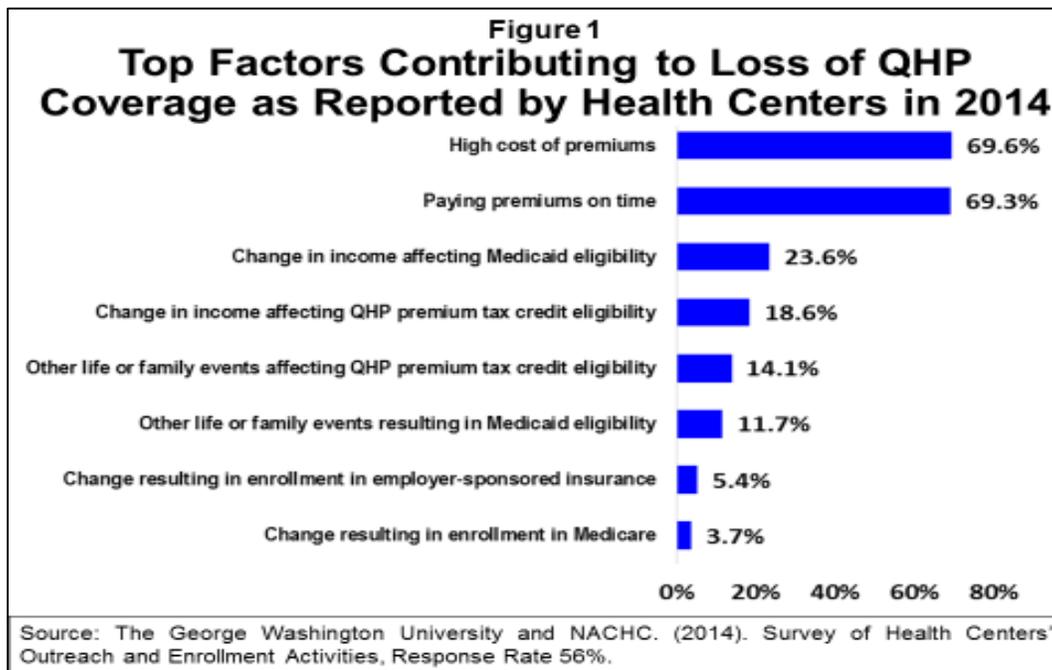
Health centers have the experience and capacity to serve at-risk populations. Most health center patients have low incomes, with 93% under 200% of the federal poverty level (FPL) and 72% under 100% FPL.² Besides primary and preventive care (which can also include lab and radiology services), most health centers provide behavioral, oral, vision, and pharmacy services.

QHP ENROLLMENT AMONG HEALTH CENTER PATIENTS

Given their broad reach into underserved communities, health centers are well suited to assist individuals in learning about their health insurance options and enrolling in plans. They also provide consistency in care as patients transition to, and among, insurance options. For example, as their incomes and life circumstances fluctuate, some patients may “churn” between Medicaid, QHPs, and being uninsured. Because health centers care for all patients, regardless of insurance status, these patients are assured stability in their care providers throughout these transitions.

Many health center patients have experienced these types of transitions since QHP coverage first became available in January 2014. According to a recent survey, 70% of health centers experienced an increase in the proportion of patients with any form of insurance between January and the fall of 2014 compared to the period prior. Of those, 56% report an increase of at least 10%—a figure likely to expand as more health center patients access insurance. Survey respondents estimate that 6% of their total patient population was enrolled in a QHP as of Fall 2014.³

The same survey also found that many patients were enrolled in a QHP but subsequently lost that coverage during the first year. Of the 28% of health centers that tracked this, nearly one-fifth (18%) reported that at least 10% of patients enrolled in a QHP lost coverage within the first year. Health centers report the biggest barriers to patients maintaining their QHP coverage cost was difficulty affording premiums and paying them on time (Figure 1).³ However, this survey did not assess challenges associated with high deductibles and cost sharing.



HEALTH CENTERS ASSIST PATIENTS WITH HIGH INITIAL OUT-OF-POCKET COSTS

Some patients who are enrolled in QHPs still have difficulty covering their deductibles and copayments, especially at the start of the plan year. Health centers ensure that eligible patients have access to timely, quality primary care by adjusting the amounts owed for health center services based on the patient's ability to pay using a sliding fee scale based on income and family size. Under this sliding fee scale, these individuals are charged no more out-of-pocket than an uninsured person with the same income and family

size would be charged for the same service. Health centers should review the contracting tips described below to avoid the need to absorb unreimbursed costs.

QHP CONTRACTING TIPS FOR HEALTH CENTERS

Most health centers (85%) report having a contract to participate in at least one QHP network.³ Health centers can more easily ensure they fully participate in QHP networks by following certain best practices.

- *Remind QHPs of the requirements and benefits of contracting with FQHCs.* Under current regulations, QHPs must contract with at least one FQHC per county, and can negotiate payment rates with that FQHC. If a QHP does not include a health center in its network, it is expected to pay the health center its Medicaid prospective payment system (PPS) rate. When negotiating potential contracts with QHPs, health centers should ensure that the QHPs are aware that they must contract with at least one FQHC per county, and that contracting with additional FQHCs can help the QHP meet the requirements to contract with at least 30% of all ECPs in their service area. Reminding QHPs of the out-of-network PPS payment requirements may also help health centers negotiate adequate payment rates. QHPs are, in fact, required to pay health centers their Medicaid PPS rates as defined in section 1902(bb) of the Social Security Act if they have not otherwise agreed upon an in-network, contracted payment rate, which may or may not be equivalent to the Medicaid rate. In situations where the QHP and health center do not agree on a contract, health centers should monitor how much their patients are expected to pay out-of-pocket for seeing a health center provider.
- *Check for conditions included in pre-existing contracts.* Although QHPs are a relatively new concept, many are offered by long-standing health insurance providers, and these insurers frequently had standing contracts with health centers prior to the launch of the Health Insurance Marketplace. These contracts often included “all products” and/or “all payers” clauses, which state that the health center agrees to participate in all current and future plans offered by the provider, and to receive the same rates. Such clauses extend existing contract terms and payment rates to QHP patients. Health centers can proactively negotiate new rates with QHPs.
- *Ensure communication on patient QHP insurance status.* Two-thirds of health centers do not receive any notice of their patients’ QHP application approval, denial, or termination.³ This means that health centers can incur unexpected financial costs for services provided to a patient after their QHP application has been denied or if their coverage is terminated due to failure to pay premiums. Fortunately, many health centers have ensured that this information is effectively communicated, thereby avoiding unexpected costs.

¹Section 45 C.F.R. § 156.235

²2013 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.

³The George Washington University and NACHC. (2014). Survey of Health Centers’ Outreach and Enrollment Activities. Response Rate 56%.