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With open enrollment beginning in October of this year, Exchange policy is still evolving, mainly because of the nature of the flexibility afforded to states. The major issues impacting Federally Qualified Health Centers (FQHCs) with regard to the requirements for Qualified Health Plans (QHPs) sold through the exchanges center around the network adequacy standards and FQHC contracting, essential health benefits and FQHC payment for services provided to QHP members.

It is important to understand that each state will have different rules that apply to participating plans. This issue brief will provide analyses of the major policy issues impacting FQHCs for the different types of exchanges (State-Based, State-Partnership and Federally Facilitated).

Key Takeaways

- Exchanges in each State will have different rules that apply to participating plans, however, in states where Federally Facilitated Exchanges (FfEs) are operational, many of these rules and policies are likely to be similar.
- QHPs are not required to contract with all FQHCs in FfEs but are subject to Network Adequacy Standards related to Essential Community Providers (ECPs).
 - In State-based Exchanges, the number of ECPs that plans must contract with will vary by State.
 - QHPs are required to pay FQHCs a PPS rate for services to QHP enrollees unless the QHP and FQHC negotiate a rate less than PPS—but since QHPs need not contract with all FQHCs, there is substantial likelihood that many FQHCs will have to negotiate a rate less than PPS to assure their contracting with QHPs. QHPs are required to pay out-of-network FQHCs PPS. However, enrollees being served by out-of-network FQHCs may be subject to high cost sharing which may impact the FQHCs due to their ability to collect.

QHP Requirements in States with State-based Exchanges

There are three different models of Exchanges that will be in place by January 1, 2014: State-based Exchanges, State Partnership Exchanges, and Federally-Facilitated Exchanges (“FfEs”). Plans that wish to participate in any one of these Exchanges must obtain certification from either the State or Federal government, depending on which Model is in place in a given State. Plans that are certified to participate in an Exchange are called qualified health plans (“QHPs”). The requirements for QHPs that operate in States with State-based Exchanges are outlined in this section. These requirements differ in some respects from the requirements that apply to QHPs operating in the FfEs, which are discussed further in the following section. For 2014, the landscape is as follows:

- **State-based Exchanges:** California; Colorado; Connecticut; District of Columbia; Hawaii; Idaho; Kentucky; Maryland; Massachusetts; Minnesota; Nevada; New Mexico; New York; Oregon; Rhode Island; Utah; Vermont; Washington
- **State Partnership Model Exchanges:** Arkansas; Delaware; Illinois; Iowa; Michigan; New Hampshire; West Virginia
- **FFEs:** Alabama; Alaska; Arizona; Florida; Georgia; Indiana; Kansas; Louisiana; Maine; Mississippi; Missouri; Montana; Nebraska; New Jersey; North Carolina; North Dakota; Ohio; Oklahoma; Pennsylvania; South Carolina; South Dakota; Tennessee; Texas; Virginia; Wisconsin; Wyomingⁱ

Network Adequacy

The Exchange Final Ruleⁱⁱ established fairly broad requirements with respect to network adequacy for QHPs in a State-based Exchangeⁱⁱⁱ. Under the final rule, a QHP issuer must ensure that the provider network of each of its QHPs meets the following standards:

- (1) Includes **essential community providers**, subject to the provisions discussed below;
- (2) Maintains a **network that is “sufficient in number and types of providers to assure that all services are accessible without unreasonable delay”**; and
- (3) Is **consistent with the network adequacy provisions of section 2702(c) of the PHS Act**, which require that any plans that use provider networks to limit their enrollment to individuals who live, work, or reside in the plan’s service area, and permit plans to close enrollment to new members if the plan does not have capacity to serve them.

Under the final rule, additional network adequacy standards may be established by the State. In other words, each State-based Exchange will have its own set of standards with respect to network adequacy for QHPs. For many QHPs in a State-based Exchange, enforcement of these standards will rest with the State^{iv}. It is not yet clear how States will approach enforcement, or which States will be stringent in ensuring that QHPs continually adhere to the network adequacy requirements established by the State.

Essential Community Providers

The Exchange Final Rule also establishes some general requirements with respect to Essential Community Providers (“ECPs”) for QHPs in a State-based Exchange^v. Under the current regulations, 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.”^{vi}

Essential community providers are defined as those providers “that serve predominantly low-income, medically underserved individuals, including providers”^{vii} defined in section 340B(a)(4) of the Public Health Service Act^{viii} and described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act^{ix}. HHS has released a non-exhaustive list of ECPs, available at the following site: <https://data.cms.gov/dataset/Non-Exhaustive-List-of-Essential-Community-Providers/ibqy-mswg>.

As with network adequacy, additional standards related to ECP participation may be set by States; enforcement of these standards will also be left to these States.

QHP Requirements in States with Federally Facilitated Exchanges (FFEs)

As noted above, CMS has clarified the requirements for QHPs that participate in an FFE. The application of these requirements may vary to a certain extent from how those requirements are applied in the State-based Exchanges.

Network Adequacy and Essential Community Providers in FFEs

The base requirements under the Exchange Final Rule for network adequacy and inclusion of ECPs in provider networks^x also apply in the FFE. According to the Letter to Issuers on Federally-facilitated and State Partnership Exchanges^{xi}, CMS will use a safe harbor standard, subject to “minimum expectations” for determining whether a QHP issuer’s application provides for sufficient inclusion of ECPs in 2014.

Proposed FFE Safe Harbor Standard for ECP Inclusion

In the Letter to Issuers, CMS says that if the Agency finds that an issuer application shows compliance with the safe harbor described below, the QHP will be determined to meet the regulatory standard, discussed above, without further documentation.

To meet the safe harbor standard, the issuer’s application must demonstrate that at least 20 percent of available ECPs in the plan’s service area *participate* in the QHP’s provider network. In addition to meeting the 20 percent participation rate, the issuer must *offer* contracts during the coverage year to all available Indian providers in the service area and at least one ECP in each ECP category (below) in each county in the service area, where an ECP in that category is available.

ECP Categories and Types in FFEs

| Major ECP Category | ECP Provider Types |
|--|---|
| Federally Qualified Health Center (FQHC) | FQHC and FQHC “Look-Alike” Clinics, Native Hawaiian Health Centers |
| Ryan White Provider | Ryan White HIV/AIDS Providers |
| Family Planning Provider | Title X Family Planning Clinics and Title X “Look-Alike” Family Planning Clinics |
| Indian Providers | Tribal and Urban Indian Organization Providers |
| Tribal and Urban Indian Organization Providers | DSH and DSH-eligible Hospitals, Children’s Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals |
| Hospitals | STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, and other entities that serve predominantly low-income, medically underserved individuals. |

The Letter to Issuers also sets forth a “minimum expectation,” under which an issuer must demonstrate that at least 10 percent of available ECPs in the plan’s service area participate in the issuer’s provider network. If a QHP only meets this minimum expectation, it must also include as part of its application a narrative describing how the QHP’s provider network in fact provides an adequate level of service for low-income and medically underserved enrollees.

Examples in CMS Letter to Issuers

The Letter to Issuers sets forth the following two examples to illustrate how a QHP in a State Partnership Model Exchange or FFE will meet these standards:

Issuer A proposes a service area in which 80 ECPs are available. Issuer A’s network includes 16 ECPs, and attests in its narrative justification that it has offered contracts to available Indian providers and one ECP in each major ECP category per county, where an ECP in that category is available. Issuer A meets the safe harbor standard; no additional documentation is required.

Issuer B also proposes a service area in which 80 ECPs are available. Issuer B's network includes 8 ECPs. Issuer B meets the minimum expectation by providing a narrative justification explaining why its network includes only 8 ECPs and how it will ensure service for low-income and medically underserved enrollees.

Requirement for QHPs That Do Not Meet the Safe Harbor Standard or Minimum Expectation

For an issuer that does not meet either the safe harbor standard or the minimum expectation, CMS will require that, as part of the application, the issuer submit a narrative justification describing why it was not able to achieve either standard. According to CMS, the justification should describe how the QHP's provider network will provide "access for low-income and medically underserved enrollees and how the issuer plans to increase ECP participation issuer's provider network(s) in future years."^{xii}

Alternative ECP Standard for Integrated Issuers

The Exchange Final Rule provides an alternate standard with respect to inclusion of ECPs in a QHP's network for certain issuers. To qualify for this alternate standard, an issuer is required to provide a majority of covered services through physicians that are employed by the issuer or through a single contracted medical group. Plans offered by these issuers must still have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities, to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area. CMS indicates that this standard will be met if the issuer complies with the safe harbor or minimum standard, above, based on employed or contracted providers located in Health Professional Shortage Areas (HPSA), or in contiguous areas, as well as in 5-digit zip codes in which 30 percent or more of the population falls below 200 percent of the federal poverty level ("FPL"). For example, "if an issuer's service area includes 50 available ECPs, the issuer would need 10 providers (20 percent of 50) in the service area that are also in or contiguous to a HPSA or low-income zip code to meet the safe harbor, and 5 providers in the service area that are in or contiguous to a HPSA or low-income zip code to meet the minimum expectation."^{xiii}

Going forward, CMS will continue to assess QHP provider networks, including ECPs; CMS indicated that the Agency may amend its approach in the future.

How Will These Requirements be Enforced?

CMS states that it will generally look to existing State compliance oversight and enforcement efforts for handling issues that fall under a State's regulatory and enforcement authority (e.g., standards that apply to all non-grandfathered individual and small-group market products). CMS also plans to investigate compliance concerns that are Exchange-specific in nature. According to the Letter to Issuers, CMS expects to use a risk-based approach to monitoring compliance, focusing initially on issuers that show signs of potential performance issues or non-compliance. CMS also indicates that the Agency will consider whether to perform periodic plan compliance reviews.

Essential Health Benefits

In addition to the Network Adequacy and ECP standards, all QHPs must cover Essential Health Benefits ("EHB"), which include at least the 10 categories of services:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services

- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

The final EHB will vary on a State-by-State basis, as determined by a State-selected or default EHB benchmark plan. A full list of each State’s EHB benchmark plan coverage is available at: <http://cciio.cms.gov/resources/data/ehb.html>.

Common Questions Regarding FQHC Participation in State-Based Exchange QHPs

Will FQHCs Still Receive the Medicaid PPS Payment Rate From QHPs?

While a QHP can offer PPS as a contracted rate, QHPs are not required to offer contracts to all FQHCs. The final rule does establish a requirement under 45 CFR 156.235(e). Specifically, the final rule states that if an item or service covered by a QHP is provided by a federally-qualified health center to a QHP enrollee, the QHP issuer must pay the FQHC 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 for such item or service. **HOWEVER, the regulations expressly permit a QHP issuer and an FQHC to establish alternative payment rates, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer.**

What Happens When FQHCs Provide Out-of-Network Services?

Some concerns have been raised about how an FQHC would be paid if it was not part of a QHP’s network. According to CMS, “a QHP issuer must pay an FQHC the relevant Medicaid PPS rate for the items and services that the FQHC provides to a QHP enrollee, if the QHP issuer and the FQHC have not contracted on a mutually agreed upon rate that is at least equal to the QHP issuer’s generally applicable payment rate.”^{xiv} CMS further clarified that this means that “if a QHP issuer does not have a contract with an FQHC [(e.g., the FQHC is out of network)], the QHP issuer must pay the FQHC the Medicaid PPS rate for the items and services provided to the QHP enrollee.”^{xv} It also appears clear that any out of network payment by the enrollee would not get applied to the enrollee’s deductible.

While these issues appear to be fairly settled, there is still an open question about the potential cost-sharing obligations that a QHP could impose on an individual for out of network services provided at FQHCs. Specifically, when an enrollee is provided care at an out-of-network FQHC, there is likely to be a significant cost sharing charge mandated by the QHP to be paid to the FQHC by the enrollee. In these situations, an FQHC would typically receive little if any of this money from the enrollee. Further, the FQHCs would still be required to file a claim with the QHP which would likely be initially denied. While they FQHC may eventually be paid for the balance of the claim, it will likely create an administrative burden on the FQHC.

Is There Any Difference With Respect to the FQHC Payment Rate for QHPs in the FFE?

No, the FQHC payment requirement would still apply to QHPs in the FFEs.

ⁱ Kaiser Family Foundation, *State Decisions for Creating Health Insurance Exchanges, as of April 1, 2013*, available at: <http://www.statehealthfacts.org/comparemaptable.jsp?ind=962&cat=17>. Accessed on April 8, 2013.

ⁱⁱ *Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule*, 77 Fed. Reg. 18310 (Mar. 27, 2012) (to be codified at 45 CFR Parts 155, 156, and 157).

ⁱⁱⁱ These requirements can be found at 45 CFR § 156.230.

^{iv} The exception to this is that the Exchange Final Rule requires the *Office of Personnel Management (“OPM”)* to ensure compliance with State-established standards with respect to Multi-State Plans (“MSPs”).

^v These requirements can be found at 45 CFR § 156.235.

^{vi} 45 CFR § 156.235

^{vii} Patient Protection and Affordable Care Act, Pub. L. No. 111- 148, § 1311 (2010).

^{viii} 340B includes the following entity types and grantees: Black Lung Clinics Program; Critical Access Hospital; Free Standing Cancer Hospital; Consolidated Health Center Program (combines Community Health Centers, School Based Programs, Health Care for the Homeless Programs, Migrant Health Programs, and Public Housing Primary Care Programs entities); Disproportionate Share Hospital; Family Planning (includes only Title X funded); Federally Qualified Health Center Look-Alikes; Tribal Contract/Compact with IHS (P.L. 93-638); Comprehensive Hemophilia Treatment Center; Ryan White Part C (formerly Title III); Native Hawaiian Health Care Program; Children's Hospital; Rural Referral Center; Ryan White Part A (formerly Title I); Ryan White Part B (formerly Title II); Ryan White Part B (formerly Title II) ADAP Rebate Option; Ryan White Part B (formerly Title II) ADAP Direct Purchase; Ryan White Part D (formerly Title IV); Sole Community Hospital; Ryan White Part F (formerly Special Projects of National Significance); Sexually Transmitted Diseases; Tuberculosis; Urban Indian.

^{ix} Defined as any entity that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Act or is State-owned or operated and would otherwise be a covered entity under 340B(a)(4), but does not receive 340B funding.

^x See 45 C.F.R. § 156.235.

^{xi} See CCIIO, *Letter to Issuers on Federally-facilitated and State Partnership Exchanges*, April 5, 2013, available at: http://ccio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf.

^{xii} *Id.* at 8.

^{xiii} *Id.* at 9.

^{xiv} Letter from Tim Hill, CCIIO, to Dan Hawkins, NACHC. June 8, 2012.

^{xv} *Id.*

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Spotlight on the States #4

Health Insurance Exchanges: Key Issues for Community Health Centers

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