Model Language for FQHC Contracting and Payment in the Exchanges

Promising Practices # 14

NATIONAL ASSOCIATION OF Community Health Centers

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This document is intended to assist health centers and PCAs in the inclusion of FQHCs in the networks of the Qualified Health Plans (QHPs) operating on States' health insurance Exchanges (or Marketplaces) and reimbursement of FQHCs by QHP issuers. We also discuss potential approaches in States that have implemented, or are considering implementing, programs (which we will refer to as "premium assistance programs") to provide Medicaid services to the "newly eligible" population under the Affordable Care Act (ACA) not directly, but instead by subsidizing QHP enrollment for that population.

While we have provided some "model language" and key points below, we note two important caveats. First, if the Exchange in your State is a federally-facilitated Exchange or State Partnership Exchange, the scope of your work may be limited to minor operational issues involving QHP networks, or (if the State is considering such an option) issues involving premium assistance programs. Second, in States with their own Exchanges, opportunities may be limited by the fact that those States have already enacted legislation or promulgated regulations establishing the Exchange.

I. Federal Minimum Standards for Exchange QHP Contracting with Health Centers

All Exchanges must comply with the ACA and its implementing regulations in establishing certification requirements for QHPs. The following are the federal requirements relating to contracting with and reimbursing FQHCs, which Exchanges must require participating QHPs to meet.

Inclusion of FQHCs in QHP networks. In Patient Protection and Affordable Care Act § 1311(c)(1), Congress recognized the critical role of health centers and other safety-net providers in QHP networks. Specifically, as a condition of certification of QHPs, Exchanges must require the QHP to

> include within health insurance plan networks those essential community providers, where available, that serve predominantly low-income, medically-underserved individuals, such as health care providers defined in section 340B (a)(4) of the Public Health Service Act . . . except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure.

In implementing regulations, HHS did not interpret the provision above as a requirement to contract with any willing provider that qualifies as a 340B covered entity -- which NACHC viewed as the correct reading of the statute. Instead, the HHS regulations describe the essential community provider ("ECP") contracting requirement as a "network adequacy" requirement that can be satisfied by contracting with a subset of ECPs. Specifically, under 45 C.F.R. § 156.235(a)(1), QHP networks must include

> 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 Marketplace's network adequacy standards.

Also relevant to the composition of QHP networks, 45 C.F.R. § 156.230 includes a general provision on network adequacy, independent of the provision on essential community providers:

> A QHP issuer must ensure that the provider network of each of its QHPs, as available to all enrollees, meets the following standards -- . . . Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to ensure that all services will be accessible without unreasonable delay. . . .

FQHC Payment. Congress also specifically required adequate payment by QHPs for services rendered by FQHCs. Under PPACA § 1302(g),

> 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) . . . to an enrollee of the plan, the offeror of the plan shall pay to the 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 such Act . . . for the service.

HHS issued implementing regulations on FQHC payment that NACHC felt unduly limited the statute. The regulations, at 45 C.F.R. § 156.235(e), repeat the language in the statute but then provide:

> Nothing in this paragraph (e) would preclude a QHP issuer and 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, so long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer. . . .

II. What Exchange QHP Contracting Standards Apply in My State?

As a starting point, it helps to understand what laws govern your Exchange. The answer depends on your State. As of January 2014, 16 States and the District of Columbia are operating their own Exchanges; 7 States are operating their Exchange in partnership with the Federal government; and 27 States are using the Federally-Facilitated Exchange.

Under ***State Exchanges***, sources of law governing QHP certification rules include

- the federal statute and regulations above
- a State implementing statute or regulation establishing the Exchange, and
- State QHP certification standards (which may be updated from year to year)

Under the ***Federally-Facilitated Exchange***, sources of law governing QHP certification include

- the federal statute and regulations above, and
- QHP certification standards that CMS establishes on a year-to-year basis

CMS released the final Letter to Issuers for 2015 in March 2014. That document represents CMS's annual implementation of Exchange QHP certification standards. The requirements regarding contracting with ECPs in the 2015 Letter to Issuers are the following:

- QHPs are required to include at least 30 percent of the ECPs in a service area in their networks;

- QHP issuers must offer contracts in "good faith" to all available Indian health care providers and at least one ECP in each ECP category in each county in the service area where an ECP in that category is available. To be offered in good faith, a contract must offer terms that a willing, similarly-situated, non-ECP provider would accept or has accepted.

As to FQHC payment, the Letter to Issuers contains helpful language regarding services provided out-of-network – *i.e.,* by a health center that does not have a provider contract with the QHP. The guidance indicates that with the exception of some closed-panel HMOs, QHPs must pay FQHCs at their PPS rate for out-of-network services. The reasoning is that for out-of-network services, the PPS rate applies since no other rate has been "mutually agreed upon" through a contract between the parties.

HHS has given States that did not establish their own Exchange the opportunity to participate in performing either plan management functions or consumer assistance and outreach on the Federally-Facilitated Exchange. In such a ***"Partnership Exchange"*** State, the governing law is the same as with a Federally-Facilitated Exchange, but the State may have some input in QHP certification standards.

III. Securing FQHC Protection in Exchange QHP Contracting and Payment Requirements

In States administering their own Exchanges, FQHCs can seek protection from the State when contracting with QHPs and ensure adequate payment for services from QHPs.

Some States, such as Delaware, have fully implemented the statutory standard from the ACA, requiring QHPs to contract with every available FQHC and to pay each contracted FQHC according to the PPS methodology. The following represent two alternative versions of "ideal" legislative or regulatory language:

1. **The Exchange shall require that each qualified health plan, as a condition of certification, shall (1) offer to any willing 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.**
2. **The Exchange shall require that each qualified health plan, as a condition of certification, shall (1) offer to any willing 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 1902(bb) of the Social Security Act, 42 U.S.C. § 1396a(bb).[1]**

Many States, however, have chosen to implement narrower standards than that quoted above, given that the HHS implementing regulations gave Exchanges flexibility in both their QHP network requirements (by requiring that QHPs

[1] The first version differs from the second only in that the first version cites the ACA statutory requirement that Exchanges reimburse FQHCs according to the Medicaid PPS methodology, while the second version cites only the Medicaid statutory provision describing that methodology. Given that in spite of the clear PPS payment guarantee at PPACA § 1302(g), the implementing regulations authorize Exchange QHPs to negotiate rates with health centers that are lower than the PPS rate, health centers or PCAs may conclude that it raises red flags with State agencies to cite the PPACA language. Health centers / PCAs may therefore find it preferable to present model language that cites only the Medicaid statute.

contract with a "sufficient number" of essential community providers, rather than all such providers) and in their FQHC payment standards (by giving Exchanges authority to allow QHPs to negotiate FQHC rates as low as the QHP's "generally applicable rate").

In States with their own Exchanges that have refused to implement a PPS payment obligation and an "any willing provider" standard for FQHC contracting similar to the model language presented above, PCAs can pursue more rigorous network adequacy standards with respect to FQHCs than those found in the HHS 2015 Letter to Issuers. That document is binding only on the Federally-Facilitated Exchanges and State Partnership Exchanges, and we do not think its standards are rigorous enough to carry out the law. For ideas on FQHC / ECP network adequacy standards to propose, we encourage you to review pages 7-10 of **NACHC's comments on HHS's 2015 Letter to Issuers**, where NACHC objected to the ECP network standards in that document and proposed more stringent network requirements (for example, a requirement that QHPs contract with a minimum of seventy percent of the ECPs in their service areas, in combination with other requirements to ensure adequate provider participation in light of service area geography and demographics). At bare minimum, in States operating their own Exchanges, PCAs should seek FQHC network representation and FQHC payment that satisfy the standards in the 2015 Letter to Issuers.

IV. Premium Assistance Programs

Some States are using Medicaid funds to implement "premium assistance programs," under which the State provides Medicaid to specific eligibility groups (particularly individuals newly eligible for Medicaid under the ACA) by subsidizing their premiums to enroll in QHPs on the Exchanges. Please see NACHC's **March 2014 State Policy Report #52, Medicaid Expansion and Section 1115 Waiver Demonstrations**, for more information on these programs.

While States can implement these arrangements under their Medicaid State Plans, that option is subject to such extensive restrictions that in practice, the States that have pursued premium assistance programs have needed to do so by seeking approval of demonstration projects under Section 1115 of the Social Security Act. HHS has wide-ranging authority to waive Medicaid requirements in a Section 1115 demonstration. For example, the only vehicle that a State can use to seek waiver of the requirements to cover FQHC services and to reimburse health centers for them at the PPS rate is a Section 1115 demonstration. However, with respect to premium assistance demonstrations, CMS has indicated in guidance that CMS will ensure that Medicaid and CHIP-eligible individuals in these programs "remain Medicaid or CHIP beneficiaries and continue to be entitled to all Medicaid/CHIP benefits and cost sharing protections." 78 FR 42184. The referenced "Medicaid benefits" include FQHC services and, by extension, the Medicaid FQHC PPS reimbursement methodology.

Under Section 1115 demonstrations, States agree to "special terms and conditions" (STCs) outlined in an agreement between the State and CMS. The STC document includes a list of specific Medicaid statutory requirements that CMS is waiving under the demonstration.

PCAs should actively monitor both State implementing legislation and draft demonstration applications. Under CMS regulations, States are required to solicit public comment on 1115 demonstration applications before submitting them to CMS, and CMS is required to solicit comment on submitted applications before acting on them. The STCs reflect the content of an approved application, so by commenting on the application, members of the public can directly impact the legal provisions that will control the demonstration project. Areas of interest include:

Network Adequacy

Under Medicaid, FQHC services are a mandatory service for categorically needy individuals, including the "newly eligible" individuals in Medicaid expansion States. In 1115 demonstrations involving Medicaid managed care, however, some States have obtained a waiver of that statutory requirement to the extent necessary to allow managed care

organizations (MCOs) to contract with a limited number of FQHCs: often a minimum of one FQHC per service area. Such language has also appeared in approved premium assistance waivers. We encourage PCAs to pursue more rigorous FQHC network requirements than this.

In practice, the FQHC network adequacy requirements on the Exchanges are typically more rigorous than those included in Medicaid 1115 demonstrations involving premium assistance. Where that is the case, since Medicaid beneficiaries will be entitled to the same access to the FQHC service as other QHP enrollees, QHPs will be required by the Exchange to adhere to the more stringent Exchange standard.

PCAs commenting on demonstration applications involving premium assistance should address the following areas:

- Provisions in demonstration applications that seek any waiver of Section 1902(a)(10)(A) (mandatory Medicaid services) as it relates to FQHC services
- STCs that ensure beneficiaries enrolled in premium assistance programs have access to FQHCs that (1) have the capacity to accept new patients, (2) are geographically accessible to Medicaid beneficiaries in the service area, and (3) are culturally competent to serve the Medicaid beneficiaries in the service area
- Additional network adequacy requirements relating to enrollee-provider ratios or maximum distance / driving time
- Participant enrollment provisions ensuring that, to the extent possible, participants in premium assistance programs may continue to receive services from their established primary care provider

If FQHC access requirements contained in a demonstration STC relating to premium assistance are more rigorous than those required of Exchange QHPs more generally, so that the Medicaid standards require access to more FQHCs than are included in the QHP network, then the State Medicaid agency must facilitate such access through Medicaid managed care plans or the Medicaid fee-for-service program.

Coverage of FQHC Services

The "benchmark benefit" to which newly eligible Medicaid enrollees are entitled includes the full scope of Medicaid FQHC services. On the other hand, the "essential health benefits" that Exchange QHPs are required to offer do not include a category that specifically corresponds to the scope of Medicaid FQHC services. States seeking to implement premium assistance through Section 1115 demonstrations have sought waivers of the FQHC service requirement in Medicaid, but to date, in keeping with its stated resolve to ensure that the newly eligible have access to the full scope of required Medicaid services, CMS has refused to grant that waiver. Instead, most premium assistance 1115 demonstrations approved to date have included a provision requiring States to provide a "wraparound" of FQHC services to the extent that components of this package of services are unavailable to premium assistance enrollees through the QHP.

PCAs commenting on demonstration applications involving premium assistance should address:

- STC terms requiring the State to provide a wraparound FQHC benefit, to the extent QHPs in a service area fail to contract with FQHCs for the full scope of their services

FQHC Payment

Federal law requires that States pay FQHCs according to the "prospective payment system" methodology set forth in Section 1902(bb) of the Social Security Act. States have sought waivers of the PPS payment requirement in 1115 demonstration applications involving managed care, but to date, with limited exceptions involving "expansion populations" (individuals eligible for Medicaid only as a result of the demonstration) or geographical regions, CMS has not waived the requirement.

Safeguarding the PPS payment guarantee is particularly important in the context of premium assistance programs because, as outlined above, HHS regulations give Exchanges discretion to contract with FQHCs for lesser payment.

Therefore, PCAs commenting on demonstration applications should address:

- Any request for a waiver of Section 1902(bb) of the Social Security Act as it relates to premium assistance participants
- STC terms that require the State to provide supplemental payments to FQHCs to ensure that they are reimbursed according to the PPS methodology for services provided to Medicaid beneficiaries enrolled in premium assistance

Premium and Cost-Sharing Restrictions

Under Medicaid, individuals with household income below 150% FPL may not be required to pay premiums for services. Only "nominal" cost sharing (including copayments, coinsurance and deductibles) can be imposed on individuals with income under 100% FPL. CMS expects States implementing premium assistance to provide a "wrap" of both premiums and cost sharing so that premium assistance participants do not bear greater cost burdens than other Medicaid beneficiaries.

States' adherence to these expectations is important to health centers. Where States impose higher premiums or cost sharing than allowed under federal law on Medicaid beneficiaries, health centers are still required to serve the patients, and typically the health center, in accordance with its sliding fee discount schedule, waives or reduces the cost sharing, imposing strains on its other revenue sources. PCAs commenting on demonstration applications should address:

- Provisions in demonstration applications that seek a waiver of Social Security Act § 1916 or 1916A to the extent necessary to impose premiums or cost sharing that exceed the levels otherwise allowed under federal law

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