PACHC Memo 13-01

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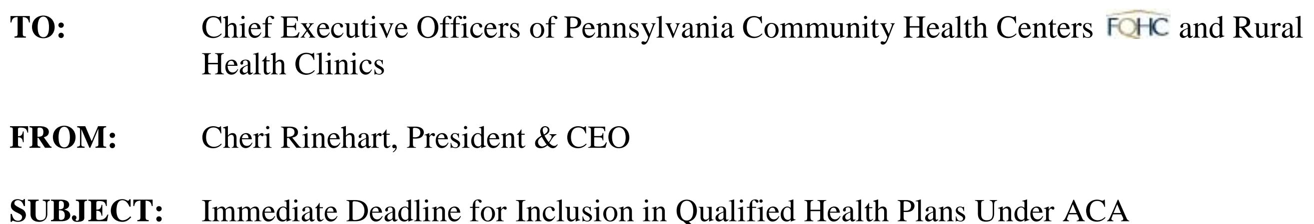
April 1, 2013



TO: Chief Executive Officers of Pennsylvania Community Health Centers FQHC and Rural Health Clinics

FROM: Cheri Rinehart, President & CEO

SUBJECT: Immediate Deadline for Inclusion in Qualified Health Plans Under ACA

SUMMARY: As a potential Essential Community Provider (ECP) under the Affordable Care Act (ACA), FQHCs, Look-Alikes and Rural Health Clinics must immediately begin engaging insurance companies in order to be included in their Qualified Health Plan (QHP) proposals by April 30, 2013.

BACKGROUND: Per the Affordable Care Act (ACA), each state will have an insurance marketplace for individuals to purchase insurance products if the individual does not have employer-sponsored coverage, commercial insurance or qualify for Medicaid/Medicare. Pennsylvania's insurance marketplace will be operated as a "federally facilitated exchange" meaning that the U.S. Department of Health and Human Services (HHS) will develop the relevant regulations and rules as well as be solely responsible for the operations of the marketplace. As such, HHS is communicating with each state to advise on the necessary steps that must be taken in order to participate in the marketplace and to have relevant services provided to individuals who will purchase products from the marketplace.

HHS has advised insurers/issuers to submit Qualified Health Plan (QHP) applications by **April 30, 2013**. Once received, these applications will be reviewed and those that are approved will sign a contractual agreement with HHS in September of 2013 and begin enrolling individuals on October 1. A QHP under the federal health care law is an insurance plan certified by an insurance marketplace that provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other minimum requirements.

QHPs must contract with "Essential Community Providers (ECP)" – providers that serve predominantly low-income, medically underserved individuals – to participate within their plans and must have a sufficient number and geographic distribution of ECPs to ensure access for low income medically underserved populations. However, QHP insurers/issuers ***are not required*** to contract with FQHCs or Look-Alikes. Furthermore, when contracting with an FQHC, they are able to negotiate a mutually agreed upon payment rate lower than the Prospective Payment System rate. QHPs must pay FQHCs the

Medicaid PPS rate for items and services provided to a QHP enrollee if the FQHC and the QHP have not contracted on a mutually agreed upon rate, but it is important to note: 1) that patients might have to pay more under these circumstances because they would be considered out of network services; and 2) FQHCs will still need to meet the sliding fee requirements for individuals served with incomes at or below 200 percent of the federal poverty level.

It is critical that all Community Health Centers FQHC begin to take steps to be included as an ECP under QHPs moving forward. This means being prepared to offer your value proposition, which includes your health center's capability, impact, validated quality and outcomes, and cost.

MEMBER ACTION: There are several steps that you can take to ensure that you become an Essential Community Provider under a Qualified Health Plan in your area. PACHC suggests you do the following immediately so that you are included in QHP applications prior to their submission at the end of the month.

- Ensure that you are listed correctly in the ECP database created by HHS as potential QHPs will use it to identify and contract with ECPs moving forward. HHS recognizes that this list is not complete so please review it carefully. If you are not listed or there is an error, please notify essentialcommunityproviders@cms.hhs.gov immediately and please copy Dawn McKinney (NACHC) at dmckinney@nachc.com and Jim Willshier (PACHC) at jim@pachc.com
    - QHPs are allowed to include providers in their application that are not listed on this database but meet regulatory standards, which should include Community Health Centers, but you should take steps to ensure that you are included correctly
- As we do not currently have a list of potential QHPs, we advise you to contact insurers/issuers in which you currently have a relationship under managed care, commercial insurance or CHIP as a starting point to ensure that you are included in their QHP prior to the April 30 deadline for submission of QHP applications.
    - You can also use information provided by the IRS on Pennsylvania's potential QHPs at http://www.irs.gov/Individuals/Pennsylvania:-State-Qualified-Health-Plans
- Review information on Essential Community Provider guidelines and the potential impact on Community Health Centers as provided by NACHC.
- As you prepare to enter into a contract with a potential QHP, keep the following under consideration:
    - □ If this QHP is a previously contracted insurer/issuer, review the original agreement terms prior to executing an amendment to include the new QHP product
    - □ If a new agreement, pay close attention to provisions related to the addition of new products and contractual amendments (for purposes other than conforming with state or federal law or regulation)
    - □ Become familiar with Pennsylvania and federal regulations referenced within the proposed agreement
    - □ Carefully review ALL associated contract documents (including all exhibits, fee schedules, utilization management program guidelines and policy and procedure manuals)
    - □ Have a clear understanding of both insurer/issuer and health center responsibilities as outlined by the agreement

- Require 30 days prior written notice to ALL changes that impact policies, procedures and reimbursement under the agreement and include language that gives the contracted health center 30 days to respond to the proposed changes
- Carefully analyze proposed rates and existing rates for the purpose of establishing a fair and competitive reimbursement structure
- Set the initial term of the agreement in such a way that health center risk is limited. The longer the term of the contract, the greater the risk, especially in a new market being established
- Outline an eligibility verification mechanism within the scope of the document
- Include tightly worded termination and arbitration provisions (*with advice of legal counsel*)
- Address how payments for denied claims are handled in a QHP environment due to unpaid premiums following the expiration of the 90-day grace period (Section 6 from 3/1/13 CCIIO letter). There needs to be a discussion between the health center and QHP insurer/issuer in regards to which party will bear the responsibility for the payment of claims in situations such as those outlined above (proposed contract language should then be modified to reflect the mutually agreed upon process)

FOR MORE INFORMATION: Please continue to follow PACHC's *News CHCs Can Use* newsletter for updates on this issue under the short timeline that QHP applications are currently operating under. You can also find more information on HHS's website dedicated to implementation of the ACA at www.healthcare.gov. As always, please feel free to contact our Director of Policy and Partnership, Jim Willshier, at jim@pachc.com or (717) 761-6443, ext. 206 for more information.