Considerations in Managed Care Contracting: Introductory Guidance

Background

Health centers can and should enter into managed care contracts or similar types of agreements. In doing so, health centers should be careful to ensure that the contract is compliant with Section 330 requirements concerning payment to health centers. Specifically, health centers are required "to make every reasonable effort…to collect reimbursement for health services to persons [covered by Medicare, Medicaid, any other public assistance program, or private health insurance] on the basis of the full amount of fees and payments for such services without application of any discount."[1] Accordingly, it is recommended that health centers be able to demonstrate that they have engaged in an assessment of the adequacy of the reimbursement for the specific range of services included in their contracts.

There are relatively few requirements set forth in federal statute or regulation addressing private commercial managed care contracting from the perspective of the health care provider (i.e., between the managed care organization and the health care provider). By contrast, with respect to Medicare and Medicaid managed care organizations,[2] federal law provides specific payment protections for FQHCs as network providers.

The law requires managed care organizations contracting with a FQHC for the provision of services to the organization's enrollees to provide payment to the FQHC which is not less than the level and amount that the managed care organization would make if the same services were furnished by a non-FQHC provider.[3] This applies even when the managed care contract is between the managed care organization and a "network," which in turn contracts with the FQHC.

Further, both the Medicaid and Medicare Advantage programs provide for supplemental or "wrap-around" payments to FQHCs. If the payment amount made to the FQHC by a Medicaid managed care organization is less than the payment amount determined appropriate by the state under its prospective payment system ("PPS") (or under a mutually agreed upon alternative payment methodology), the state must provide the FQHC with a supplemental payment equal to

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1 Section 330(k)(3)(G)(ii)

2 Both the Federal Government and states contract with private health plans to arrange services to Medicare and Medicaid enrollees, respectively. Under the "Medicare Advantage" program, health plans (which include health maintenance organizations ("HMOs") preferred provider organizations ("PPOs"), and private fee-for-service plans) provide services under Part A (hospital services) and Part B (physician services, including FQHC services) to Medicare beneficiaries. Under the "Part D" program, prescription drug plans provide pharmacy services for Medicare beneficiaries. Similarly, HMOs provide services to Medicaid recipients under Medicaid managed care programs.

3 See 42 U.S.C. § 1396b(m)(2)(A)(ix) (Medicaid); 42 U.S.C. § 1395w-27(e)(3)(A) (Medicare Part C, also known as "Medicare Advantage").

the amount by which the PPS (or alternative) amount exceeds the amount of payment provided to the FQHC by the managed care organization.[4] The state must make wrap-around payments to health centers no less than every four months.[5]

Similarly, in the Medicare Advantage program, if the payment made to the FQHC by the Medicare Advantage plan is less than the rate under Medicare's prospective payment system ("PPS"), the Federal Government must provide the FQHC with a supplemental payment equal to the amount by which the Medicare PPS exceeds the amount of payment provided to the FQHC by the managed care organization.[6] In other words, total payment to the health center should equal 100 percent of the PPS amount. The Centers for Medicare and Medicaid Services, the government agency responsible for the Medicare program, must make wrap-around payments to FQHCs on at least a quarterly basis.[7]

Finally, the Patient Protection and Affordable Care Act of 2010 ("PPACA"), which provides for the establishment of Health Benefit Exchanges ("Exchanges") in each state, also includes specific payment protections for FQHCs. Under PPACA, states were required to implement an Exchange by January 1, 2014.[8] PPACA requires that the Qualified Health Plans ("QHP") offering coverage on the Exchanges contract with "essential community providers," such as health centers, where they are available.[9] PPACA also requires that the QHP pay the FQHC, for any FQHC service that is covered by the QHP, "an amount that is not less than the amount of payment that would have been paid" under the Medicaid FQHC payment provisions in federal law.[10]

Implementing regulations require QHPs to pay FQHCs according to Medicaid PPS methodology for items or services provided by the FQHC and covered by the QHP.[11] The QHP, however, need not contract with an essential community provider (ECP) that refuses to accept the "generally applicable payment rates of such issuer."[12] In the preamble to the final rule, published in March 2012, HHS clarified that "'generally applicable payment rate' means, at a minimum, the rate offered to similarly situated providers who are not essential community providers."[13] Under the final rule, HHS "interpret[ed] these two provisions to mean that a QHP issuer must pay an FQHC the relevant Medicaid PPS rate, or may pay a mutually agreed upon

4 See 42 U.S.C. §1396a(bb)(5).
5 Id. §1396a(bb)(5)(B).
6 See 42 U.S.C. § 1395w-23(a)(4)(A), citing 42 U.S.C. § 1395l(a)(3)(B).
7 Id.
8 If a state elects not to establish an Exchange, or the Federal Government determines that the state is unable to have an Exchange operable in the state, the Federal Government will establish and operate the Exchange.
9 Patient Protection and Affordable Care Act §§ 1311(c)(1)(C).
10 Id. § 1302(g).
11 45 C.F.R. § 156.235(e).
12 45 C.F.R. § 156.235(d).
13 77 Fed. Reg. 18422 (Mar 27, 2012).

rate to the FQHC, provided that such rate is at least equal to the QHP issuer's generally applicable payment rate."[14]

In a June 8, 2012 letter, the Deputy Director of HHS's Center for Consumer Information and Insurance Oversight confirmed the agency's stance that the law requires a QHP to pay an FQHC the relevant Medicaid PPS rate for the items and services that the FQHC provides to a QHP enrollee, if the QHP does not have a contract with the FQHC.[15] In other words, the PPS rate serves as the level of payment the FQHC would receive as an out-of-network provider.

Advice and Recommendations[16]

A managed care contract template offered by an MCO at the outset of contract negotiations may contain provisions that either are inconsistent with or make it difficult for health centers to comply with certain operational requirements particular to FQHCs under the Public Health Service Act, or under Medicare or Medicaid rules. Health centers should demand that any such provisions be omitted from the contract.

For example, managed care contracts often include a provision prohibiting a provider from waiving applicable cost-sharing requirements imposed on the enrollee, e.g., co-insurance, co-payments or deductible. This prohibition conflicts with the requirement under Section 330 that health centers "assure that no patient will be denied health care services due to an individual's inability to pay for such services; and … assure that any fees or payments required by the center for such services will be reduced or waived to enable the center to fulfill [such] assurance…"[17] Thus, managed care contracts need to allow health centers to waive or reduce otherwise applicable cost-sharing amounts when such waiver or reduction is necessary to prevent the denial of services.[18]

In addition, managed care contract provisions requiring providers to maintain a certain level of professional malpractice insurance for the health center and its employees and contractors, or to indemnify the managed care organization for any liability resulting from the health center's actions or non-actions, may conflict with Section 330 provisions concerning Federal Tort Claims Act ("FTCA") coverage for health centers. The contract should clearly state that, in lieu of

[14] Id.; see 45 C.F.R. § 156.235(e).

[15] Letter from Timothy Hill, Deputy Director, Center for Consumer Information and Insurance Oversight, U.S. Department of Health and Human Services, to Daniel R. Hawkins, Jr., Senior Vice President, National Assoc. of Community Health Centers (June 8, 2012) (on file with the authors).

[16] The Authors of these materials include attorneys at the law firm of Feldesman Tucker Leifer Fidell LLP. The advice and recommendations consist of general guidance based on federal law and regulations and do not necessarily apply to all health centers under all facts and circumstances. Further, these materials do not replace, and are not a substitute for, legal advice from qualified legal counsel.

[17] See Section 330(k)(3)(G)(iii).

[18] The Anti-Kickback Statute specifically allows Federally-Qualified Health Centers to waive or reduce cost-sharing amounts for Medicare and Medicaid beneficiaries who qualify for subsidized services under Section 330 of the Public Health Act, i.e., patients with incomes at or below 200% of the Federal poverty line.

professional malpractice insurance, the managed care organization will accept the health center's FTCA coverage (if the health center is deemed by HRSA as FTCA-covered). The FTCA does not cover indemnification of third parties. Therefore, the health center should either refuse to agree to a contract provision requiring such indemnification or, if it accepts such a provision, should obtain adequate "gap" insurance to cover indemnification clauses.[19]

With regard to Medicare Part D (the prescription drug benefit), many contracts with prescription drug plans ("PDPs") require a pharmacy to serve all enrollees of the plan. However, many health center pharmacies operate as a "closed pharmacy" (i.e., only serve individuals who are patients of the health center) because, as a "covered entity" participating in the 340B Drug Pricing Program, the health center must restrict dispensing of medications to health center patients. Health center contracts with PDPs should allow the health center to operate as a closed pharmacy.

Consequently, the Authors recommend that health centers carefully review managed care contracts prior to execution to ensure that the contracts do not contain provisions contrary to, or inconsistent with, health center-specific requirements under Section 330 or FQHC protections under the Medicare and Medicaid regulations.

For example, contracts with Medicaid and Medicare health plans should incorporate the requirement, discussed above, that the plan's payments to FQHCs be equal to or greater than the plan's payments to non-FQHC providers for the same or similar services. (This can be accomplished through a provision that the plan "warrants" or "represents" that the payment rates comply with this standard.)

Finally, particular states may have promulgated contracting requirements between managed care organizations and health care providers as components of their insurance or managed care organization laws and regulations. Therefore, the Authors suggest reviewing managed care contracts to ensure compliance with all applicable state laws and regulations.

- Third party payor and managed care contract terms impacting health center statutory, regulatory, and policy requirements: Checklist

[19] For more information regarding the FTCA, see Providing care and the Federal Tort Claims Act: Introductory guidance.