CHCANYS DEFINING NEW DIRECTIONS
COMMUNITY HEALTH CARE ASSOCIATION OF NEW YORK STATE

Policy/Advocacy News

Dear Health Center Leaders,

We understand that some community health centers have started to receive proposed provider contracts from health plans intending to bid to participate in the New York Health Benefit Exchange (the Exchange). Here is some important information regarding FQHCs and the Exchange.

In 2012, Governor Cuomo signed an Executive Order to establish a New York Health Benefit Exchange. The State expects to enroll over 1 million New Yorkers in coverage through the Exchange. All of this must happen within a relatively short time frame, as the Exchange will begin accepting enrollees into health plans beginning in October of 2013.

New York State residents who are not eligible for Medicaid will be able to purchase health insurance through the New York Health Benefit Exchange. Low and moderate income individuals will qualify for tax credits and cost-sharing benefits to reduce the cost of health insurance purchased through the Exchange. Small employers with up to 50 employees will also be able to access coverage for their employees via the Exchange.

The Exchange is federally required to provide health insurance plan networks that include "essential community providers" who serve predominantly low income, medically underserved individuals, such as health providers defined in Section 340B of the Public Health Service Act, including FQHCs. At this time, it is our understanding that the Exchange is using the same network adequacy standards as the State Medicaid Plan: at least 1 FQHC per county. We continue to press the State to increase this standard to better reflect "access issues;" however, the request for applications released by the State to health plans includes the 1 FQHC per county standard.

Another aspect of the Exchange of particular importance to FQHCs is the section of the Affordable Care Act (ACA) that discusses payment to FQHCs. Section 1302(g) of the ACA law requires in the context of the Exchange:

If any item or service covered by a qualified health plan is provided by a Federally-qualified health center as defined in [the Medicaid section 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 [I.e., the PPS rate]. Emphasis added.

We have been in discussion with the State regarding this provision, and they too will be working to educate health plans planning to apply to participate in the Exchange about this requirement. Some of the applicant health plans currently only operate in the government program space and are accustomed to the State paying the wrap differential between the PPS and the negotiated rate. It is possible that these health plans do not yet understand that the State will not be responsible for the wrap for non-Medicaid products included in the Exchange. Similarly, while centers are free to negotiate their rates, centers should know that there will be no State wrap to make up the difference between the PPS and a negotiated rate below the PPS.

For additional background information, we suggest reading the NACHC Policy Brief entitled, *"Final Medicaid and Exchange Regulations: Implications for Federally Qualified Health Centers,"* which was produced in April of 2012. CHCANYS has also asked Exchange staff to facilitate a training session for health centers. As soon as the details of this webinar have been finalized, we will send out registration information for the event.

We hope you find this information helpful. We will continue to share information and resources on the Exchange to help you prepare over the coming months.

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