

Report

Prepaid Ambulatory Health Plans (PAHPs): Implications for Safety Net Providers

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Introduction

Since the 1970s, federal Medicaid law has both defined and set program participation standards for, those classes of entities that will be considered qualified to participate in state Medicaid managed care programs.¹ This background memorandum examines one such entity known as the “prepaid ambulatory health plan,” (PAHP) which has been established as a newly recognized form of managed care arrangement under the final Medicaid managed care rule issued by the Centers for Medicare and Medicaid Services (CMS) in June, 2002.²

We begin with a brief background that reviews the evolution of Medicaid managed care conditions of participation and the various entities recognized as qualified to participate in Medicaid prior to June, 2002. We then discuss the June 2002 final Medicaid managed care regulation and the provisions relating to PAHPs to review applicable structural and performance standards. We conclude with an assessment of the implications of this new rule for safety net providers and populations served by the Health Resources and Services Administration (HRSA).

Background and Overview

Traditionally the task of defining and regulating health care institutions and organizational enterprises has rested with state government as a health care licensure function.³ With the enactment of Medicare and Medicaid in 1965, the federal government established an important new precedent of using large federal payment programs to establish organizational, structural, and process-of-care conditions for enterprises that sought to participate in public insurance programs.

The original Medicare and Medicaid statutes contained no federal standards for prepaid health care arrangements, although Medicaid participation by precursors of the modern

¹ Section 1903(m) of the Social Security Act, 42 U.S.C. §1396b(m).

² 42 C.F.R. §438.2, 67 *Fed.Reg.* 41097 (June 14, 2002).

³ Rand Rosenblatt, Sylvia Law and Sara Rosenbaum, *Law and the American Health Care System* (Foundation Press, NY, NY, 1997); Rand Rosenblatt, Sara Rosenbaum and David Frankford, *Law and the American Health Care System* (2001-2002 Supplement).

managed care enterprise (e.g., staff and group model prepaid group practices such as Group Health and Kaiser Permanente) actually dates back to 1965.⁴

Following the prepaid health plan scandals of the 1970s,⁵ the federal government became far more actively involved in managed care regulation. The first statutory standards appeared in federal law in 1976 and essentially restricted managed care participation to federally recognized HMOs or state-licensed prepaid group plans that served even numbers of public and private purchasers.⁶ Beginning with the Omnibus Budget Reconciliation Act of 1981, subsequent federal legislative amendments relaxed and finally eliminated this public/private participation standard in the case of comprehensive service HMO-style plans⁷ and provided the Secretary with authority to permit state Medicaid programs to contract with alternative types of managed care arrangements through so-called “freedom of choice” waivers.⁸ Under federal regulations and guidelines issued during the 1980s, two basic classes of alternative managed care practice arrangements emerged: primary care case management (PCCM) arrangements and prepaid health plans (PHPs).

While federal guidelines permitted considerable flexibility in the formation and use of these alternative arrangements, certain patterns did emerge within these authorized contractual arrangements. A typical PCCM arrangement involved a contract for primary care and case management between a state Medicaid agency and a primary care group practice, with payment for both primary medical care and case management services made on a fee-for-service (FFS) basis.

In a PHP arrangement, the Medicaid agency would enter into limited service risk contracts with entities that were not licensed or regulated as HMOs or comprehensive service prepaid group health plans but nonetheless bore financial risk for one or more services. The use of PHPs allowed states that lacked a comprehensive HMO-style service market for their Medicaid beneficiaries to enter into risk-bearing primary care and special purpose managed care contracts without violating federal law. During the period when HMOs had to evidence a public/private membership mix in order to satisfy federal conditions of participation, PHPs and PCCM arrangements were exempt from this requirement and could conduct business on a Medicaid-only basis. From providers’ viewpoint, the PHP and PCCM programs represented a means of participating in managed care-style contracts (including risk arrangements) without having to form (or be part of) entities that could satisfy federal requirements applicable to comprehensive service plans.

⁴ Robert Stevens and Rosemary Stevens, *Welfare Medicine in America: A Case Study of Medicaid* (Free Press, New York, NY, 1974).

⁵ These unregulated, under-capitalized entities fraudulently acquired and operated large prepaid group practices in order to conduct business exclusively with state Medicaid programs.

⁶ Section 202(a) of the Health Maintenance Organization Amendments of 1976 (P.L. 94-460). This public/private participation requirement was known as the “50/50” rule. For additional information, see Law and the American Health Care System, op. cit.

⁷ Id. The Balanced Budget Act of 1997 (P.L. 105-33) eliminated the public/private participation rule, following several years in which the Clinton Administration waived federal statutory conditions of participation to permit states to experiment with Medicaid-only comprehensive service managed care arrangements.

⁸ This legal authority is found in §1915 of the Social Security Act, 42 U.S.C. §1396n.

The recognition of PCCMs and PHPs restored a considerable level of contractual flexibility that had been eliminated through the federal HMO amendments that restricted managed care style contracts to a limited range of entities. PHPs and PCCMs were essentially unregulated, except for the relatively modest standards established in the federal guidelines that created them.⁹ As a result, standards that applied to comprehensive service plans, such as capitalization, payer mix, and service and compensation rules, did not apply to these entities.

For the first time, the Balanced Budget Act of 1997 (BBA), which significantly overhauled and restructured federal Medicaid standards applicable to managed care, codified in statute both comprehensive service arrangements (renamed managed care organizations (MCOs)) as well as other arrangements (known as managed care entities).¹⁰ The BBA also formally recognized in statute the concept of primary care case management. Regulations promulgated by the Clinton Administration in January 2001 implemented these amendments by recognizing three types of managed care entities: managed care organizations (MCOs); prepaid health plans; and primary care case management arrangements.¹¹ The rules identified the conditions of participation applicable to each class of provider, with prepaid health plans subject to virtually all requirements applicable to MCOs.

The January 2001 final regulation defined "prepaid health plans" as:

an entity that- (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; and (2) does not have a comprehensive risk contract.¹²

Thus, under the January 2001 final regulation, these prepaid health plans were required to comply with the same standards of care, other consumer safeguards, and external review provisions as managed care organizations.¹³

To recap, as of January 2001, state Medicaid programs were given three basic options where federally recognized managed care contracts were concerned:

- A state agency could enter into a comprehensive risk contract with a managed care organization that as a condition of participation was required to comply with a range of service and management requirements as well as various consumer protection safeguards. In addition, state contracts with MCOs were subject to relatively extensive federal regulations, including rates of compensation.

⁹ 42 C.F.R. §431.55 et. seq. (2000)

¹⁰ Andy Schneider, Overview of Medicaid Managed Care Provisions in the Balanced Budget Act of 1997, December 1997, available at http://www.kff.org/content/archive/2102/budget_rep.html.

¹¹ 66 *Fed.Reg.* 6228 (January 19, 2001).

¹² 42 C.F.R. §438.2, 66 *Fed.Reg.* 6405 (January 19, 2001).

¹³ See Sara Rosenbaum and Colleen Sonosky, *An Analysis of the Bush Administration's Proposed Medicaid Managed Care Regulations*, GWU Center for Health Services Research and Policy, September 2001, available at http://www.gwhealthpolicy.org/downloads/nprm_analysis.pdf.

- Alternatively, an agency might contract with a prepaid health plan offering more limited services but still subject to virtually all contractual and participation requirements applicable to comprehensive managed care service contracts.
- Finally, a state could develop a PCCM system using limited service contracts for primary care and case management. PCCM contracts are subject to relatively modest regulation in the areas of services and consumer safeguards.

The June 2002 Final Medicaid Managed Care Rule

The proposed rule in August 2001 and the June 2002 final Medicaid managed care rule further modified the Medicaid managed care market into four, rather than three, separate categories of entities:

- The regulation retained the MCO and PCCM categories; and
- At the same time, the regulation further separated the PHP category of managed care entity separated prepaid health plans into two categories: "prepaid inpatient health plans" (PIHPs) and "prepaid ambulatory health plans" (PAHPs).

What separates PIHPs and PAHPs is their relationship to inpatient care services. A managed care entity would be considered a PIHP if it provides medical services on the basis of prepaid capitation payments, and if it "provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees."¹⁴ In contrast, a PAHP is defined as an entity that:

- (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;
- (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and
- (3) does not have a comprehensive risk contract.¹⁵

The Preamble to the August 2001 NPRM provides the following explanation for the agency's decision to reformulate PHPs into PAHPs and PIHPs:

These two definitions include all entities that were previously defined as PHPs, but make a distinction between those responsible for at least some (but not all) inpatient hospital or institutional care an enrollee receives, as in the case of large behavioral health plans, and those that are not, such as dental or transportation plans and capitated PCCMs.¹⁶

¹⁴ 42 C.F.R. 438.2, 67 *Fed.Reg.*41097 (June 14, 2002).

¹⁵ *Id.*

¹⁶ 66 *Fed. Reg.* 43620 (August 20, 2002).

In response to comments questioning the division between PIHPs and PAHPs, CMS maintained the separate definitions of these two entities by explaining:

There are clear differences in terms of the degree of financial risk, contractual obligation, scope of services, and capitation rates paid to these different types of entities. ... Recognizing that the scope of contractual responsibility for these larger PHPs, now designated PIHPs, was far more like the responsibilities in MCO contracts, we have imposed most MCO requirements on these entities. The PAHP designation allows us to impose requirements on this smaller group that are more appropriate to the scope of services they are obligated to provide. Not only do we believe it is unnecessary to subject prepaid dental plans, transportation providers, and capitated primary care case managers to the same standards as MCOs and PIHPs, it is not logical to impose the same administrative burdens on contractors who receive a fraction of the amount in capitation rates that MCOs and PIHPs are paid. ... Finally, we believe that the distinction is clear between PIHPs and PAHPs and MCOs. If an entity has less than a comprehensive risk contract, but has any responsibility for an enrollee's inpatient hospital or institutional care, it is a PIHP and subject to all PIHP requirements.¹⁷

Although CMS has noted that the distinction was drawn in order "to impose requirements that more accurately reflect the scope of benefits that [the entity] contracts to provide,"¹⁸ there is nothing in the rule itself that limits use of PAHPs to only special purpose situations, such as prepaid dental plans or transportation services. Indeed, the PAHP rule is broad and sufficiently flexible to permit the establishment of risk contracts with far-flung primary and specialty network-style entities, as long as the contractor *is not responsible for the provision of inpatient care*. This language would not appear to preclude risk-based ambulatory care management contracts in which the contractor authorizes the use of inpatient care or shares in inpatient savings (e.g., disease management contracts).

In the August 2001 proposed rule, PAHPs were exempted from a number of patient protections applicable to PIHPs. In considering the issues raised by commenters on the exempted provisions, CMS revised the final regulation to include additional provisions of the regulation in the areas of notice, information, contract and quality requirements that should apply to PAHPs.¹⁹ These changes require PAHPs to comply with the provisions relating to:

- *Advance directives;*
- *Access to medical records*
- *Access standards for appropriate network of providers;*
- *Demonstration of adequate capacity;*
- *Special needs service obligations, including access to specialists, enrollee identification and assistance, and care coordination;*

¹⁷ 67 Fed. Reg. 40996 (June 14, 2002).

¹⁸ 66 Fed. Reg. 43620 (August 20, 2001).

¹⁹ 67 Fed. Reg. 41007 (June 14, 2002).

- *Coverage and authorization of services;*
- *Re-credentialing and oversight of provider selection;*
- *Confidentiality protections; and*
- *Subcontractor relationships.*

Under the final Medicaid managed care rule, PAHPs, unlike MCOs and PIHPs, are now eligible for three major exemptions:

- *Quality improvement:* The elements of state quality strategies and ongoing quality assessment and performance improvement programs do not apply to PAHPs.
- *Grievance system:* PAHPs would be exempt from the obligation to establish a grievance system.
- *Program integrity and certification:* PAHPs would be exempt from requirements to track fraud and abuse or certification of data for payment purposes, including a mandatory compliance plan.

The Preambles in the Final Rule and the NPRM set forth several reasons for drawing a distinction between PIHPs and PAHPs, and providing different requirements between the two entities. CMS noted that “there are clear differences in terms of the degree of financial risk, contractual obligations, scope of services, and capitation rates paid to these different types of entities, and that the scope of rules that apply to these entities under this regulation should reflect these distinct differences.”²⁰ In addition, with the added PAHP requirements, CMS explained that they have “maintained an appropriate level of regulatory requirements for [PAHPs] and provided the necessary degree of flexibility for States to implement these programs and impose any additional requirements necessary.”²¹

The NPRM’s Preamble notes that the BBA and the proposed rule are chiefly intended to apply to MCOs, the most comprehensive form of risk contractor. In the agency’s view, the level of protection set out in the proposed rule “are also appropriate for those PHPs that are responsible for a benefit package that closely resembles the risk comprehensive range of services provided by MCOs.”²² At the same time, the August 2001 Preamble notes, “[W]here PHPs contract to provide a much more limited array of services, such as transportation or dental care, we believe applying the same requirements would not be appropriate. Thus, we are making a distinction between these two types of entities based on whether they are responsible for all or some of the inpatient hospital or institutional services needed by their enrollees.” The two-tiered approach allows states the “flexibility necessary for innovative contracting,” and to apply regulatory requirements that are appropriate to the range of services under the contract. The preamble clarifies that PCCMs that also meet the definition of PAHPs (i.e., contractors that operate on a capitation or alternative payment basis) would be deemed to be PAHPs and subject to PAHP requirements to the extent that they augment those applicable to PCCMs.

²⁰ 67 *Fed. Reg.* 41007 (June 14, 2002).

²¹ *Id.*

²² *Id.*

Implications of NPRM for Safety Net Providers and Vulnerable Populations

The Medicaid managed care Final Rule has contrasting implications for HRSA health care providers and programs and the vulnerable populations served by HRSA. On the one hand, the existence of the PAHP standards permit somewhat greater ease of market entry into the Medicaid risk contracting business for HRSA grantees that undertake capitated primary health care or specialty contracts such as dental contracts. The relaxation of quality performance, grievance and appeals procedures, and program integrity certification means that the obligations on managed care entities are lower and their participation, correspondingly simpler. To the extent that state law does not subject PAHP contractors to the standards applicable to other risk contractors, entities can more easily form and compete for business. Simultaneously, a state's contracts with PAHPs, as well as its oversight activities in relation to PAHPs, are exempt from the most significant requirements applicable to MCOs and PHPs.

For vulnerable populations, the implications may be somewhat different. The BBA added numerous protections for Medicaid managed care enrollees in exchange for elimination of the public/private participation standards for HMOs. In the view of CMS, this *quid pro quo* is applicable only in the case of comprehensive service contracts or their equivalent. At the same time, the proposed PAHP regulations, while purporting to apply to a few limited types of arrangements, in fact allow the virtual equivalent of an HMO to exist outside of the 1997 protections. While a PAHP is not allowed to *provide or arrange for* inpatient care under the rules, nothing in the final rule formally limits the reach of a PAHP to dental plans or ambulatory transportation. A PAHP could furnish or manage a full range of contractual benefits as long as it is careful to stop at the point of actually providing or arranging for inpatient care. Contracts that create PAHP arrangements potentially could be structured to permit *authorization* activities that are distinct from "providing or arranging for" activities.

To the extent that PAHPs become a widely used mechanism, the net effect could be the loss of some patient safeguards considered necessary by Congress in the case of risk contracts that assign decision-making power over health care access to private contractors operating on a financial risk basis. If one considers the true focus of Congressional concern to be the confluence of risk contracting and the contractual power to control access -- rather than the more narrow and simplistic question of the duty to *provide* inpatient care -- then the PAHP distinction may be a case of elevating form over substance in order to avoid certain safeguards considered essential by Congress. At particular risk would be patients with high health care needs who make extensive use of specialty services and who need to be in network arrangements operating under relatively rigorous access and quality standards. In this regard, HRSA might wish to pay particular attention to the evolution of PAHP arrangements that are set up to provide specialty care or manage special needs patients.

January 19, 2001 Rule	June 14, 2002 Final Medicaid Managed Care Rule
<p>Following requirements apply to PHPs to the same extent as they apply to MCOs:</p> <ul style="list-style-type: none"> • contract requirements of 438.6 • information requirements • provider discrimination requirements • state responsibilities • enrollee rights and protections • quality assessment and performance improvement • grievance systems • certification and program integrity protections <p>Following requirements do not apply to PHPs:</p> <ul style="list-style-type: none"> • requirements that pertain to HIOs • advance directive requirements in dental/non-clinical services such as transportation • state plan requirements 	<p>Following requirements apply to PIHPs to the same extent as they apply to MCOs:</p> <ul style="list-style-type: none"> • contract requirements of 438.6 • information requirements • provider discrimination requirements • state responsibilities • enrollee rights and protections • quality assessment and performance improvement • grievance systems • certification and program integrity protections <p>Following requirements do not apply to PIHPs:</p> <ul style="list-style-type: none"> • requirements that pertain to HIOs • state plan requirements <p>Following requirements apply to PAHPs:</p> <ul style="list-style-type: none"> • contract requirements in 438.6 • all applicable information requirements • provider discrimination provisions • state responsibilities • enrollee rights and protections • availability of services requirement in 438.206(a) • designated portions of quality assessment and performance improvement • enrollee's right to a state fair hearing <p>Following requirements do not apply to PAHPs:</p> <ul style="list-style-type: none"> • requirements that pertain to HIOs • services such as transportation • state plan requirements • designated portions of information requirements