



**DEPARTMENT OF HEALTH & HUMAN SERVICES**  
**Health Care Financing Administration**

**Center for Medicaid and State Operations**  
**7500 Security Boulevard**  
**Baltimore, MD 21244-1850**

April 20, 1998

Dear State Medicaid Director:

This letter is one of a series that provides guidance on the implementation of the Balanced Budget Act of 1997 (BBA). The purpose of this letter is to provide initial guidance on changes in Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) requirements stemming from BBA. In addition, we are including (as an attachment) a section which clarifies certain managed care contracting and cost-based reimbursement issues that were in effect prior to the BBA provisions.

### **New Reimbursement Provisions**

#### **Supplemental Payments**

For services furnished on or after October 1, 1997, FQHCs and RHCs are entitled to reasonable cost-based reimbursement as subcontractors of section 1903(m) organizations. States are required to make supplemental payments, at least on a quarterly basis, for the difference between the rates paid by a 1903(m) organization (such as an HMO or HIO) to an FQHC or RHC and the reasonable cost of FQHC or RHC subcontracts with the 1903(m) organization. Beginning in Fiscal Year 2000, the difference States will be required to pay begins to phase-down from 100 percent; specifically, 95 percent of reasonable cost in FY 2000, 90 percent in FY 2001, 85 percent in FY 2002, and 70 percent in FY 2003.

The issue of election of cost-based reimbursement for these specific contractual arrangements (between FQHCs/RHCs and 1903(m) organizations) is a moot point since, beginning October 1, 1997, the election process is no longer required. Before States assess the need for a supplemental payment, States should work with FQHCs and RHCs to determine what the reasonable cost levels are for each FQHC/RHC expected to participate in the program. Then, based upon the State's assessment of whether or not the rate negotiated between the FQHC or RHC and the 1903(m) organization covers the FQHC's or RHC's reasonable costs, a supplemental payment may or may not be triggered.

#### **Prohibition of Delegation of Supplemental Payment Requirement to MCOs**

Section 4712(b) of BBA requires States to make up the difference, if any, between the amounts paid FQHCs or RHCs by MCOs with which they have a contractual relationship, and the amount the FQHC or RHC would have received under the reasonable cost-based reimbursement provision contained in section 1902(a)(13)(C)(I) of the Social Security Act. The language in that section specifically requires States to make these supplemental payments. It is our conclusion that this requirement cannot and should not be delegated to an MCO, and that each State must determine any differences in payment and make up these amounts.

#### **Development of Comparison Rates**

Section 4712(b)(2) requires that rates of payment between FQHCs/RHCs and MCOs shall not be less than the amount of payment for a similar set of services with a non-FQHC/RHC. The intention of this provision is to ensure that managed care entities negotiate rates of payment with FQHCs and RHCs that are comparable to the rates paid to similar providers that do not have an FQHC or RHC designation and thereby protects the State against negotiated rates that are excessively low in comparison to the community standard.

There are two issues that are relevant here in terms of comparison rates: 1) How does the State determine what the FQHC's/RHC's costs are in order to assess whether or not there is a need for a supplemental payment; and 2) How does the State make a determination of whether the level of payment between the MCO and FQHC/RHC is not less than the rates paid for a similar set of services provided by a non-FQHC/RHC?

On the first issue, States already have in place, as part of their existing State Plans, approved methodologies for determining an FQHC's/RHC's costs (and, as noted earlier, these costs should be determined in advance of assessing the need for a supplemental payment). If a State chooses to develop an alternative methodology for the purposes of BBA, it may do so but it must also submit a State Plan Amendment. The State payment system for the supplemental payments may utilize prospectively determined rates or may pay interim rates subject to reconciliation. Irrespective of the type of payment method utilized, the rates must cover the FQHC's/RHC's reasonable costs.

On the second issue, a State has the flexibility to develop its own methodology for determining whether rates paid by MCOs to FQHCs/RHCs are not less than to other similar providers of services.

### **Phase-Out of Cost-Based Reimbursement**

Beginning in fiscal year 2000 (as noted above), as part of a phase-out of cost-based reimbursement, levels of reimbursement will be reduced both for FQHCs/RHCs participating in fee-for-service (unrestricted or as PCCM providers), and those receiving supplemental payments as HMO or HIO subcontractors. In addition, cost-based reimbursement requirements consistent with BBA remain in effect for primary care case management programs until fiscal year 2000, at which point the statutory phase-out provisions become effective. Further, FQHC cost-based provisions as required by BBA are applicable in States that have both PCCM and MCO programs. States may, at their option, continue to provide reasonable cost-based reimbursement beyond this point in time, but are not required to do so.

### **Prohibition of Requirement for Higher Payments By MCOs**

Under the pre-BBA law, States were allowed to delegate the requirement for cost-based reimbursement to MCOs. While section 4712(b)(2) of BBA places a floor on payments, it does not put a ceiling on payments (the law is silent). While the literal text of BBA does not impose an upper limit on what a State may require an MCO to pay FQHC/RHC contractors, we recognize that permitting States to impose such requirements could result in access problems and have the opposite impact on MCO-FQHC/RHC contracting arrangements than what was intended by Congress. (That is, Congress intended to encourage contracting between FQHCs/RHCs and MCOs and to remove financial barriers to this contracting.) Therefore, it is our conclusion that States cannot impose any requirement on MCOs for payments to FQHCs/RHCs other than those contained in 4712(b)(2).

### **Alternative Reimbursement Agreements**

Based upon a review of the BBA FQHC/RHC reimbursement provisions, it is our conclusion that these provisions preclude any alternative reimbursement arrangements (between a State, 1903(m) organizations, and FQHCs and RHCs, or any combination thereof) that are inconsistent with the requirements of BBA. In other words, HCFA will not approve any FQHC/RHC reimbursement arrangements that do not meet the requirements of section 4712(a), (b), and (c).

### **Effective Dates**

Unlike other BBA provisions that are effective with contracts beginning on or after October 1, 1997, the FQHC/RHC provisions under BBA affect contracts that existed prior to October 1, 1997 (e.g., July 1, 1997 - June 30, 1998) by applying to services furnished on or after October 1, 1997. All contracts (between the State and MCO and the MCO and FQHC/RHC) which this affects should be appropriately amended to reflect all the relevant changes in FQHC/RHC law and policy as noted above.

If you have any questions, please contact Sidney Trieiger at (410) 786-6612 or Matt Barry at (410) 786-1176.

Sincerely,

/s/

Sally K. Richardson  
Director  
Center for Medicaid and State Operations

Attachment

cc:

Dr. Earl Fox, HRSA Administrator HCFA Regional Administrators PHS Regional Administrators Jennifer Baxendell, NGA Lee Partridge, APWA Joy Wilson, NCSL National Association of Community Health Centers State Health Commissioners HCFA Press Office

## **ATTACHMENT**

### **FQHC Contracts and Cost-Based Reimbursement: Pre-October 1, 1997**

Prior to the effective date of the FQHC provisions contained in BBA, the rules surrounding FQHC access and cost-based reimbursement were governed by statute (section 4704(b) of OBRA 1990 amended sections 1903(m)(2)(A) and 1905(a)(2)(C)) and through HCFA policy that was issued on February 8, 1996. It is the intent of this policy statement to provide further guidance on these "old" FQHC rules in the event there are outstanding or unresolved issues with potential retroactive (pre-October 1, 1997) implications.

As stated in the February 1996 policy, appropriate contract language between the State and the managed care organization (MCO) and between the MCO and the FQHC will help to assure the receipt of cost-based reimbursement under managed care. The absence of such contractual language providing for cost reimbursement for FQHC services has been at the heart of most of the issues HCFA had to address over the past few years on FQHC policy. Typically, when FQHCs contracted for other than reasonable cost-based reimbursement, the contracts did not specify that the FQHCs waived their right to reasonable cost-based reimbursement; rather, they reflected the negotiated agreed upon payment rates. In some instances, FQHCs questioned the binding nature of their signed contracts, and whether the contracts could have been amended at the point in time which the FQHC wishes to elect reasonable cost-based reimbursement. Our guidance on this specific issue is:

The terms and conditions of contractual agreements which were entered into between FQHCs and managed care organizations are binding upon both parties. To assure that all parties in the contracting process were fully informed of the terms and conditions, including provisions surrounding cost-based reimbursement, the State should have included language in its contracts with MCOs on this (and any other) specific issue. Further, a decision (a signed contract) to contract for payments other than reasonable cost is binding on both parties (absent any additional measures by the State to reimburse FQHCs) and the contracts do not need to have specific language specifying that an FQHC is withdrawing its right to reasonable cost reimbursement. By signing such contracts, an FQHC is deemed to have waived its rights to cost-based reimbursement.

An additional concern involves the timing of the reasonable cost election for FQHCs which previously elected otherwise. Specifically, does the new election take place at the next contract renewal period, or if the original contracts provide for a redetermination of rates, can it take place at the time of the redetermination? Our guidance on this specific issue is:

If, during the course of an existing contract, an FQHC exercised its right to cost reimbursement (in writing), payments constituting cost should have then been applied at the next contract renewal or if the existing contracts had a clause where rates were redetermined (other than for automatic items such as cost-of-living adjustments or inflation), at the time of redetermination. This assumes that the FQHC negotiated appropriate contract terms at this point in time.

Where concerns remain over a State's implementation of these policies prior to October 1, 1997, HCFA is willing to consider such instances on a case-by-case basis. In such situations, HCFA strongly recommends that any such case be documented to the maximum extent possible since any HCFA decision would be based on a review and assessment of the relevant paper trail (e.g., contracts, letters between parties).