September 27, 2000

Dear State Medicaid Director:

This letter provides guidance on three policy areas pertaining to Federally Qualified Health Centers/ Rural Health Clinics (FQHCs/RHCs). FQHCs/RHCs are a critical part of the health care delivery system's safety net. The nation's most vulnerable, low-income, uninsured Americans have relied on the health care they can receive in these facilities. We take our stewardship of these facilities seriously and are committed to helping sustain a healthy, functioning health care safety net. The Health Care Financing Administration's (HCFA's) policy regarding the areas of phase-down of cost-based reimbursement, financial incentives, and managed care organization (MCO) insolvency are outlined below.

Phase-Down of Cost-Based Reimbursement

As indicated in our April 21, 1998 guidance, the Balanced Budget Act of 1997 (BBA) amended section 1902(a)(13)(C) of the Social Security Act (the Act) to provide that, for services furnished on or after October 1, 1997, FQHCs/RHCs subcontracting with MCOs are entitled to reasonable cost-based reimbursement. States must make supplemental payments (at least quarterly) to FQHCs/RHCs that subcontract with MCOs representing the difference, if any, between the MCO's payment to the subcontracting FQHC/RHC and the payment to which the FQHC/RHC would be entitled for the services under the Act (100 percent reasonable cost or the phase-down percentage as specified in the State Plan). If a State opts to pay less than 100 percent and its State Plan specifies 100 percent, then the State must amend its State Plan to reflect the phase-down percentage. Beginning in fiscal year (FY) 2000, the payment FQHCs/RHCs would be entitled to begins to phase-down from 100 percent; specifically, 95 percent of reasonable cost in FY 2000.

The Balanced Budget Refinement Act of 1999 (BBRA) further amends section 1902(a)(13)(C) to slow the phase-down of cost-based reimbursement for FQHCs/RHCs to 95 percent of reasonable cost in FY 2001 and FY 2002, 90 percent in FY 2003, and 85 percent in FY 2004. States may choose to pay above the minimum required phase-down percentage specified in the Act for a particular fiscal year up through 100 percent of reasonable cost. If a State should choose to pay above the minimum requirement, Federal Financial Participation (FFP) will be available in State payments up to 100 percent of reasonable cost.

The BBRA also amends section 1915(b) of the Act such that effective October 1, 2004, States may

request a waiver of section 1902(a)(13)(C) FQHC/RHC payment provisions under 1915(b) waiver authority. This date coincides with the end of the phase-down schedule described above.

Inclusion of Financial Incentives in a State's Calculation of Supplemental Payments

Section 1902(a)(13)(C)(ii) of the Act requires States to make supplemental payments (at least

quarterly) to FQHCs/RHCs that subcontract with MCOs representing the difference, if any, between the MCO's payment to the subcontracting FQHC/RHC and the payment to which the FQHC/RHC would be entitled for the services under the Act. Under the Act, the FQHC is entitled to either 100 percent of reasonable cost or the phase-down percentage, as specified in the State Plan. The State must determine if the reasonable cost reimbursement to which the FQHC/RHC would be paid under the State Plan for services provided exceeds the amount of payments provided under the subcontract with the MCO, and if so, it must pay the difference to the FQHC/RHC.

MCOs frequently use their own funds to include financial incentives in their contracts with subcontracting providers. Financial incentives provide the subcontractor with an incentive to reduce unnecessary utilization of services or otherwise reduce patient costs. Such incentives may be negative, such as withholding a portion of the capitation payments. If utilization goals are not satisfied, the subcontractor foregoes the withheld amount in whole or part. Incentives may also be positive, such as a bonus that is paid if desired utilization outcomes are achieved. In both cases, we believe these incentive amounts (whether positive or negative) are separate from the MCO's payment for services provided under the subcontract, do not include any additional Federal funding, and should not be included in the State?s calculation of supplemental payments due the FQHC/RHC.

Inclusion of incentive amounts (whether positive or negative) in calculating supplemental payments would negate the financial impact the incentive is designed to provide, since the FQHC/RHC would get the same total amount of money, regardless of whether it met the utilization or other goals set by the MCO. For this reason, we have determined that the State's quarterly supplemental payment obligation should be determined using the baseline payment under the contract for services being provided, without regard to the effects of financial incentives that are linked to utilization outcomes or other reductions in patient costs.

MCO Insolvency

In order to ensure that FQHCs/RHCs are paid reasonable costs under the Act, the State is required to include, as part of supplemental payments, monies that FQHCs/RHCs subcontracted to receive but did not receive from an insolvent MCO. HCFA will provide FFP for the State's payment. Ultimately, the State, on behalf of the FQHC/RHC, is eligible to receive any settlement funds that the FQHC/RHC recovers through bankruptcy proceedings.

If you have questions or need additional clarification regarding this policy guidance, please contact Cheryl Tarver at (410) 786-5451.

Sincerely,

/s/ Timothy M. Westmoreland Director

cc: Dr. Earl Fox - Administrator, Health Resources and Services Administration All HCFA Regional Administrators All HCFA Associate Regional Administrators for Medicaid and State Operations All PHS Regional Administrators Matt Salo - Director of Health Legislation, National Governors' Association Lee Partridge - Director, Health Policy Unit, American Public Human Services Association Joy Wilson - Director, Health Committee, National Conference of State Legislatures

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