Explanation of the Health Care Financing Administration’s September 27, 2000 Letter to State Medicaid Directors regarding Reimbursements to Federally Qualified Health Centers

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for more information, please contact:

Chris Koppen
National Association of Community Health Centers, Inc.
1330 New Hampshire Avenue, NW, Suite 122
Washington, DC  20036
202/659-8008 – 202/659-8519 fax

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Issue Brief Prepared

by

Chris Koppen
National Association of Community Health Centers, Inc.
1330 New Hampshire Avenue, NW, Suite 122
Washington, DC 20036
202/659-8008 – 202/659-8519 fax
ckoppen@nachc.com
Introduction

In 1999, Congress passed the Medicare, Medicaid, and SCHIP Refinements Act, also known as the Balanced Budget Refinements Act (BBRA). This legislation modified the 1997 Balanced Budget Act provisions that phased-down and eventually eliminated Medicaid reasonable cost reimbursement for federally qualified health centers (FQHCs). On September 27, 2000, the Health Care Financing Administration HCFA released a letter to State Medicaid Directors (LSMD) outlining policy changes made by the BBRA. This letter includes several additional important policy guidances, including (1) the exclusion of financial incentive payments from Medicaid managed care organizations to health centers in the State’s calculation of supplemental (or “wrap-around”) payments, and (2) State reimbursement to health centers in the event of a Medicaid MCO becoming insolvent.

This issue brief will examine each of these issues and provide additional information regarding the implementation of these policies.

Summary of LSMD Regarding Reimbursements for FQHCs

Phase-Down of Cost-Based Reimbursement and Requirements on Changing State Plans to Reflect Phase-Down

Modification of BBA’s Cost-Based Reimbursement Phase-Down Rates

In the first section of this letter, HCFA reaffirms the requirement in Federal law that FQHCs are entitled to reasonable cost-based reimbursement.¹ HCFA specifies that health centers, including health centers that subcontract with MCOs, are entitled to payment equal to at least the percentage of reasonable cost provided under Federal law. The BBRA modified the BBA’s phase-out rates in the following manner:²

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Old BBA Phase-Out Rate (% of reasonable cost)</th>
<th>New BBRA Phase-Out rate (% of reasonable cost)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY2000</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>FY2001</td>
<td>90%</td>
<td>95%</td>
</tr>
<tr>
<td>FY2002</td>
<td>85%</td>
<td>95%</td>
</tr>
<tr>
<td>FY2003</td>
<td>70%</td>
<td>90%</td>
</tr>
<tr>
<td>FY2004</td>
<td>No federal reasonable cost mandate for FQHCs</td>
<td>85%</td>
</tr>
<tr>
<td>FY2005</td>
<td>No federal reasonable cost mandate for FQHCs</td>
<td>No federal reasonable cost mandate for FQHCs</td>
</tr>
</tbody>
</table>

¹ Section 1902(a)(13)(C) of the Social Security Act

² This Issue Brief was written on October 16, 2000. As of this date, federal Medicaid law still provides for the phase-out of reasonable cost reimbursement for FQHCs as described above. However, it is possible that Congress will legislate a prospective payment system for FQHCs that would provide an alternative payment system effective October 1, 2000, in which case the phase-out rates noted in the table above would no longer be effective for fiscal years after FY2000.
Under the methodology established by the BBA, the State may not require a MCO to reimburse health centers at a rate greater than the MCO pays any other provider for similar services. The State must then, in turn, reimburse health centers the difference between the rates received by the FQHC from the MCO and the percentage of reasonable cost currently required under Federal law. The LSMD reiterates that HCFA will provide Federal Financial Participation (FFP) for States that elect to continue reimbursing health centers at 100% of their reasonable cost. HCFA made the same commitment in its LSMD of October 23, 1998.

**Requirement of Modification of State Plan to Implement BBRA’s Phase-Down Rates**

In an important clarification of Federal policy, HCFA requires that any State that chooses to implement the BBRA’s phase-out must modify its State Medicaid plan to do so. In their letter, HCFA states, “if a State opts to pay less than 100% and its State Plan specifies 100%, then the State must amend its State Plan to reflect the phase-down percentage.” This requirement is important for health centers in those States that have decided to implement the BBRA’s phase-down percentage.

NACHC urges all health centers in States that have decided to implement the BBRA’s phase-down to determine whether the State has filed a State plan amendment. If a State has been paying FQHCs less than 100% of reasonable cost, and its State plan provides for 100% reimbursement, NACHC believes that health centers in that State are entitled to reimbursement up to 100% of costs.

**Waiver of Reasonable Cost Reimbursement under Section 1915 Waivers**

In the LSMD, HCFA notes that the BBRA also amends Medicaid’s freedom of choice/managed care waiver provision (Section 1915(b) of the Social Security Act) to allow a State, as of FY2005, to waive reasonable cost protection for FQHCs under these waivers. The law currently prohibits waiving FQHC reasonable cost reimbursement under 1915(b) managed care waiver programs. However, after FY2004 FQHCs are no longer entitled to reasonable cost reimbursement. The LSMD clarifies that States may then request a waiver of the FQHC reasonable cost mandate. This clarification in the LSMD does not seem necessary since, as currently written, FQHC entitlement to reasonable cost ends as of FY2005. Consequently, there is no reasonable cost mandate to waive.

**Inclusion of Financial Incentives in a State’s Calculation of “Wrap-Around” Payments**

As Medicaid has turned to managed care for the coordination and delivery of health care services to Medicaid beneficiaries, health centers have been confronted by a variety of mechanisms that MCOs use to reduce or redirect utilization of services or otherwise reduce costs. These mechanisms come in the form of payment withholds or incentive bonuses to provide for meeting (or failure to meet) particular performance goals.

Unfortunately, several States have attempted to reduce Federally required “wrap-around” payments to health centers by including the financial incentive payments made by a MCO to a health center in its calculation of reasonable cost payments owed to health centers. Under this
approach, a State would require that a health center include MCO bonus payments in its cost report and subsequently the State would reduce reasonable cost “wrap-around” payments to centers by the amount of these bonus payments. This reduced the “wrap-around” payments that a health center was entitled to and eliminated any financial incentive that a health center may have to meet performance targets. It also had the effect of allowing MCOs and other providers (such as hospitals or specialty care providers) to benefit financially from savings that result substantially from an FQHC’s primary care and preventive services.

In the second section of the LSMD, HCFA clarifies that a State may not include any incentive amounts in its calculation of “wrap-around” payments to FQHCs regardless of whether such incentive payments are a return of a withheld portion of capitated payments or a bonus over and above the FQHCs capitated payments. In the letter, HCFA states

“...the State’s quarterly supplemental [“wrap-around”] 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.”

In light of this clarification of policy, NACHC urges all health centers to review and reevaluate their reimbursement rates and payments from the State to ensure that financial payments that health centers have received from meeting MCO performance measures are not included in the State’s calculation of the amount the health center received (or should have received) from the State in “wrap-around” payments.

Health centers might also review the State’s treatment of such incentive payments retroactive to the effective date of the BBA (October 1, 1997), since that is the beginning date on which State Medicaid agencies were required to make “wrap-around” payments to FQHCs. Particularly important, health center should review carefully existing and new contracts with MCOs to be sure that the incentive payments are clearly articulated and identified in these agreements so that there can be no question by the State that such payments are not to be included in the State’s calculation of “wrap-around” payments due the health center. Health centers that are not contracting directly with MCOs, but rather, are contracting with networks (IPAs, etc.), that, in turn, contract with Medicaid MCOs, should also review their agreements for this same purpose.

**Payments to Health Centers in the Event of MCO Insolvency**

The third section of this LSMD addresses payments to subcontracting health centers in the event that a MCO becomes insolvent. Under this policy, HCFA clarifies that a FQHC that subcontracts with a MCO that subsequently becomes insolvent is entitled to reasonable cost payments. HCFA requires States to include the amount that the FQHC was entitled to under the MCO subcontract, but did not receive because the MCO became insolvent, in its calculation of the amount of supplemental payments due to the FQHC.

If a MCO becomes insolvent, a State will receive FFP for the additional payments it makes to health centers to assure their receipt of reasonable cost. If the FQHC recovers any funds resulting from bankruptcy proceedings, the FQHC must pay the State those amounts.
Conclusion

This LSMD is an important clarification of Federal policy regarding Medicaid payments to Federally qualified health centers. NACHC urges health centers to examine these policies carefully to ensure that they are appropriately reimbursed for services provided to Medicaid patients. If they have questions, please call Chris Koppen at NACHC (202) 659-8008, or Roger Schwartz at Feldesman, Tucker, Leifer, Fidell & Bank at (202) 466-8960.

Enclosure: September 27, 2000 Letter to State Medicaid Directors