

## Issues Affecting FQHCs in Final Rule on Medicaid Managed Care and State Health Official Letter 16-006

In late April 2016, CMS issued two documents that can have significant impacts on how FQHCs interact with their state Medicaid agencies and Medicaid Managed Care Organizations (MCOs):

- The [Final Rule on Medicaid Managed Care](#), a 1400+-page document that marks the first major regulatory update to the program in over a decade. This Final Rule aims to modernize the program, and thus covers an extensive list of provisions impacting Medicaid beneficiaries, providers and MCOs.
- [State Health Officials Letter #16-006](#), which addresses limits on states' ability to "delegate" FQHC wrap-around payments to MCOs, and broadens requirements on MCOs to contract with FQHCs.

When the proposed rule was issued last year, NACHC submitted extensive comments on a number of managed care issues impacting FQHCs. Below is a summary of these comments, along with an overview of how CMS responded in the Final Rule and SHO.

Please note that ***these and other requirements may not apply in a state that has an 1115 waiver***. Each state's 1115 waiver is unique, so if your state has an 1115 waiver, you should work with your state Medicaid agency to determine which requirements are waived.

- **MCOs must consider Section 330 requirements when requiring FQHCs to assume risk**
  - NACHC Comment: NACHC requested that CMS explicitly prohibit states and MCOs from *requiring* FQHCs to assume risk for services beyond primary and preventive care as a prerequisite for obtaining a MCO provider agreement.
  - Final Rule: CMS did not explicitly prohibit these types of requirements. However, it did include a discussion of the limitations that Section 330 of the Public Health Service Act places on health centers' ability to assume risk, and require that these be taken into account when designing VBP arrangements.
- **Value-Based Payment (VBP) arrangements must adhere to statutory requirements around PPS**
  - NACHC Comment: NACHC requested that CMS explicitly state that states and MCOs may not require FQHCs to participate in VBP arrangements that violate statutory requirements for PPS.
  - Final Rule: As requested, CMS explicitly states that (absent an 1115 waiver) VBP arrangements must adhere to the statutory requirements for payment, such as FQHC PPS (i.e., FQHCs must be paid no less than what they would receive under PPS, and must agree individually to the arrangement).
- **Incentive payments from MCOs must be in addition to – not subtracted from - PPS payments**
  - NACHC Comment: As an example of a specific type of VBP arrangement, NACHC requested that CMS explicitly state that incentive payments made to FQHCs (e.g., for meeting quality goals) must be in addition to – not used to offset -- PPS payment rates.
  - Final Rule: As requested, CMS explicitly stated that incentive payments FQHCs must be in addition to – not used to offset -- PPS payment rates.

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- **No minimum Federal standards for Network Adequacy; states must set their own standards.**
  - NACHC Comment: NACHC requested that CMS establish minimum network adequacy standards that all MCOs must meet for a specified provider types, including primary care and OB/GYN. NACHC also recommended that these minimum standards address: time and distance to reach a provider; wait time for appointments; language and physical accessibility; and accessible hours for working populations.
  - Final Rule: The Final Rule requires all states to establish have network adequacy standards that its MCOs must meet (specifically around time and distance to various types of care.) However, the Rule did not specify any minimum standards; rather, these decisions are left entirely to individual states.
  
- **Each MCO must contract with at least one FQHC and one RHC per service area starting July 2017**
  - NACHC Comment: NACHC requested that CMS require MCOs to contract with Essential Community Provider (ECPs) - including FQHCs – according to the same requirements that apply to Qualified Health Plans (QHPs) sold under the Marketplaces.
  - Final Rule and SHO 16-006: The Final Rule did not require MCOs to adhere to the same ECP contracting requirements as QHPs. However, SHO 16-006 requires each MCOs to contract with at least one FQHC and one RHC in each of its service area starting July 2017. Note that:
    - At present, in areas with mandatory managed care, contracting requirements are limited to one MCO per service area being required to contract with one FQHC.
    - Each state may choose how to define “service area”, and one service area can cover a very large geographic area.
  
- **CMS fails to protect FQHCs from costs resulting from credentialing delays, saying it is a state issue**
  - NACHC Comment: NACHC requested that CMS protect FQHCs from the unreimbursed costs they incur while waiting for MCOs to approve credentialing applications for their individual providers. (These costs are due to many MCOs refusing to reimburse FQHCs for services provided to their patients prior to the provider’s application being approved, which can take many months). Specifically, NACHC requested that CMS: establish a maximum timeframe for MCOs to review applications; require retroactive reimbursement for services provided to MCO patients by providers whose applications were under review; and require MCOs to post how long they take to review applications.
  - Final Rule: CMS rejected all of our recommendations, stating that all decisions regarding credentialing should be made at the state level.
  
- **Choice Counseling:**
  - NACHC Comment: CMS proposed that states be permitted to provide funding to licensed enrollment brokers to provide “Choice Counseling” services to MCO patients. These services are almost identical to the O&E services that FQHCs currently provide to Medicaid MCO patients. However, most FQHCs are not licensed as enrollment brokers, as this requires meeting standards established by individual states. Therefore, NACHC requested that FQHCs be eligible to receive state funding to provide Choice Counseling without being licensed as enrollment brokers by their state
  - Final Rule: CMS rejected our recommendation, finalizing the requirement that State Medicaid funding to perform Choice Counseling may only be provided to organizations that have been licensed as enrollment brokers by their state.

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- **No clarity on whether states or MCOs can force FQHCs to carve out Medicaid from 340B**
  - NACHC Comment: NACHC asked CMS to explicitly state that neither states nor MCOs may prohibit 340B providers who are in MCO networks from using 340B drugs for their patients.
  - Final Rule: CMS refused to address this issue in the Final Rule, stating that it is outside of the scope of the proposed rule. (Note that NACHC is engaged in continuing discussion with CMS and HRSA on this issue, in collaboration with representatives of other 340B-eligible providers).
  
- **No clarity on whether 340B savings from MCO patients should accrue to states or FQHCs**
  - NACHC Comment: NACHC requested that CMS state that any savings achieved when a 340B drug is dispensed to a MCO patients are to accrue to the FQHC (or other 340B-eligible provider).
  - Final Rule: CMS did not address this issue in the Final Rule, stating that it is outside the scope of what the proposed rule. Thus, it did not state that these savings should accrue to the FQHC. However -- contrary to what it did in a recent Final Rule about drugs dispensed to fee-for-service patients --- it did not finalize policies which would send these savings to the state. As a result, this question -- whether the savings on drugs provided to MCO patients go to FQHCs or the state -- is currently being decided at the state level.
  
- **States may “delegate” their responsibility to make FQHC wrap-around payments to MCOs only if the arrangement meets the statutory requirements for an APM**
  - NACHC Comment: NACHC submitted extensive legal analysis indicating that states may not “delegate wrap” to MCOs without meeting the statutory requirements for an Alternative Payment Methodology (APM), and requested that CMS clarify these requirements in the Final Rule.
  - Final Rule and SHO 16-006: While CMS did not address this issue in the Final Rule, it addressed it at length in SHO 16-006. The SHO states clearly that (absent a Section 1115 waiver), states may not delegate their responsibility to make FQHC wrap-around payments to MCOs unless these arrangements meet the statutory requirements for an APM – namely:
    - 1.) each impacted FQHCs must individually agree to receive delegated wrap, and
    - 2.) total reimbursement to each FQHC must be no less than what it would have received under PPS.

**For More Information:**

- For a summary of the full Final Rule, see the [CMS release](#) and this [Health Affairs summary](#).
- For FQHC-specific questions, please contact [Susan Sumrell](#) or [Colleen Meiman](#) in NACHC’s Regulatory Affairs Department