

Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs

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Preface

We are pleased to share with you this comparative description of the Rural Health Clinic (RHC) and the Federally Qualified Health Center (FQHC) programs. This version has been updated to reflect changes and clarifications since the document was last updated in 1995.

Both programs offer very real opportunities for enhancing access to health care in underserved rural areas. The following information provides a basic description of the programs, including some complexities and unique aspects of each.

The Health Resources and Services Administration (HRSA) has prepared this document to help health care practitioners understand the differences in the programs and the benefits that each offers in their decisions. We trust you will find it useful.

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Introduction

The primary intent of this document is to provide a general comparison of the financial components of the Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) programs under Medicare and Medicaid. While the document also provides some discussion of the programmatic comparisons between RHCs and FQHCs, a full review of the separate programmatic and regulatory requirements for RHCs and FQHCs that receive funding under Section 330 of the Public Health Service Act is beyond the scope of this paper. With the growth in the number of practices converting to RHC or FQHC status, and growing interest in the development of networks, health care organizations in underserved areas are presented with an opportunity to improve revenues and expand their services, as well as the challenge of deciding which opportunity can best meet their goals. Some of the organizations and individuals likely to be interested in these programs include:

- Private practices considering conversion from fee for service to cost-based reimbursement
- Critical Access Hospitals (CAHs)
- Current RHCs considering conversion to FQHC status
- Migrant health programs
- Health care for the homeless programs
- Health care for public housing programs
- Tribal health care programs
- Free Clinics
- Hospitals and state health planners seeking methods to support primary care in underserved areas
- Providers such as physicians, physician assistants (PAs), nurse practitioners (NPs), certified nurse midwives (CNMs) and others
- Boards of directors, administrators, and fiscal personnel involved in strategic planning for their organizations

In order to present these programs as thoroughly as possible, this document includes a brief history of both the RHC and FQHC programs, an overview of the theory of cost-based reimbursement, and a description of the differences in eligibility criteria, programmatic requirements, and covered services. Finally, there is a description of the possible financial effect of cost-based reimbursement. This description is very basic and useful only for demonstration purposes. A thorough analysis needs to be performed when

considering a change in reimbursement methods.

This document does not attempt to describe every aspect of each program. Rather, it focuses on those aspects where there are differences between an RHC and an FQHC. There are several issues, particularly in the areas of Medicare benefits and cost finding principles, which are common to both programs, and therefore, not described.

In 2000, Congress changed the way both RHCs and FQHCs are reimbursed under Medicaid. The cost-based reimbursement system was replaced by a Prospective Payment System (PPS) developed exclusively for RHCs and FQHCs. In addition, States were given greater flexibility to create new payment mechanisms for RHCs and FQHCs. In considering either the FQHC or RHC option, you are strongly encouraged to contact your State Medicaid office to determine the specific policies that have been put in place for RHCs or FQHCs in your State.

In 2002, Congress created a new “facility” shortage designation for both RHCs and FQHCs. Under this new authority, individual RHCs and FQHCs can be designated as health professional shortage area (HPSA) facilities thereby permitting participation in the National Health Services Corps program, as well as other programs that utilize the HPSA designation as a criterion for eligibility.

Both the RHC and FQHC programs offer tremendous opportunities to communities or entities interested in pursuing either of these options. It is important, however, to pursue RHC or FQHC designation for the right reasons. The intent of these programs is to help make health care available in communities or to individuals where it might be difficult or impossible utilizing traditional fee-for-service or capitated payment methodologies.

It is important to keep in mind that while Medicare or Medicaid payments for services may be better in the aggregate than under other payment formulas, these payment methodologies are simply intended to cover the clinic’s or center’s reasonable costs.

Chapter 1

Legislative Background

Background Description of the Rural Health Clinic Program

The Rural Health Clinics Act (P.L. 95-210) was passed by Congress and signed into law by President Carter in 1977. The goal of this Act was twofold. First, it encouraged the utilization of PAs and NPs by providing reimbursement for services these health professionals provided to Medicare and Medicaid patients, even in the absence of a full-time physician. Second, it created a cost-based reimbursement mechanism for services when provided at clinics located in underserved rural areas.

Because of subsequent changes in the Medicare law authorizing Medicare Part B coverage for PAs and NPs in all practice settings, not just RHCs, the original incentive for utilizing PAs and NPs was diminished. However, because an RHC gets reimbursed the same amount from Medicare and Medicaid regardless of whether the patient is seen by a mid-level provider (MLP) such as a PA, NP, CMN, or physician, the facility continues to have a strong incentive to utilize these practitioners whenever it is clinically appropriate.

P.L. 95-210 specified that regulations implementing the RHC Act define a set of RHC services, often referred to as “core” services. These services, detailed in the covered scope of services chapter of this document, are to be reimbursed by Medicare on the basis of an All Inclusive Reimbursement Rate (AIRR) reflecting the cost of the services. Furthermore, these services must be included in each State’s Medicaid plan as required Medicaid services.

The Benefits Improvement and Protection Act of 2000 (BIPA) dramatically changed the way State Medicaid programs must reimburse RHCs. In lieu of cost-based reimbursement, Medicaid now pays RHCs using a PPS methodology. This PPS methodology varies by State and the payment rate may be clinic specific.

Background Description of the FQHC Program

The term “Federally Qualified Health Center,” or FQHC, refers to three different types of clinics:

- Health Centers (HCs) funded under Section 330 of the Public Health Service (PHS) Act, including Community Health Centers (CHCs), Migrant Health Centers (MHCs), Health Care for the Homeless Health Centers (HCHs), and Public Housing Primary Care Centers (PHPCs); (Note: Information regarding HCHs and PHPCs is not included in this publication. Further information regarding these programs may be found at <http://www.bphc.hrsa.gov>)
- FQHC “Look-Alikes,” or FQHCLAs, that have been identified by HRSA and certified by CMS as meeting the definition of “Health Center” under Section 330

- of the PHS Act, although they do not receive grant funding under Section 330;
and
- Outpatient health programs/facilities operated by tribal organizations (under the Indian Self-Determination Act) or urban Indian organizations (under the Indian Health Care Improvement Act).

The FQHC program [enacted under the Omnibus Budget Reconciliation Act of 1989 (ORBA 89) and expanded under the Omnibus Budget Reconciliation Act of 1990 (OBRA 90)] provides for cost-based reimbursement under Medicare and Medicaid for legislatively specified services.

The FQHC program was a logical extension of the Community/Migrant Health Center (CHC/MHC) programs enacted in the 1960s and 1970s. The original CHC/MHC programs provided Federal grants to Community Health Centers (CHCs) or Migrant Health Centers (MHCs) for the care of uninsured individuals. These facilities received no special Medicare or Medicaid payments.

Congress created the FQHC program to allow special Medicare and Medicaid payments for CHCs and MHCs thereby ensuring that grant dollars intended for the uninsured were available for that purpose. In order to extend the CHC/MHC concept, Congress also authorized the special Medicare and Medicaid payments for clinics that operate in compliance with the requirements of the FQHC program, but that do not receive grant funding under Section 330 of the PHS Act. These clinics are commonly known as “Look-Alikes”.

All FQHCs receive cost-based reimbursement from Medicare based upon the same payment principles as RHCs. As was mentioned above with respect to the RHC program, the Benefits Improvement and Protection Act of 2000 (BIPA) dramatically changed the way State Medicaid programs must reimburse FQHCs. In lieu of a retroactive cost-based reimbursement, Medicaid now pays RHCs using a PPS methodology based on the historical reasonable costs of the center. This PPS methodology varies by State and the payment rate may be clinic specific.

Chapter 2

Cost Based Reimbursement Advantages and Disadvantages

Theory

In a fee-for-service practice, revenue is estimated on the basis of procedures, such as office visits, lab tests and x-rays. The practice anticipates the number of procedures they will perform and the revenue associated with each of these procedures.

In an RHC/FQHC, revenue is estimated on an average cost per visit (up to a cap, if applicable) for each Medicare visit. If, for example, an all inclusive reimbursement rate of \$60.00 is established, that rate is the reimbursement received for each face-to-face encounter by the practice, regardless of the number or type of procedures provided during a visit, as shown below.

	Procedure	Fee-for-Service Payment	Cost Reimbursement Payment (Clinic's AIRR)
Patient #1:	Office Visit	\$39.00	\$60.00
	Total	\$39.00	\$60.00
Patient #2:	History and Physical	\$35.00	\$60.00
	Lab Tests	15.00	15.00
	Set & Cast Fracture	50.00	0
	Total	----- \$100.00	----- \$75.00

Medicare will reimburse the practice 80 percent of the All Inclusive Reimbursement Rate (AIRR) and the patient will be responsible for 20 percent of the usual and customary charge. In order to project revenue, clinic/center managers need to determine total payments from Medicare fee-for-service (Part B) and the total number of Medicare visits. These figures would then be used to determine the clinic's average payment per visit from Medicare Part B, which could then be compared with the AIRR the clinic/center projected if it converted to RHC or FQHC status.

The change from analyzing payments on a fee-for-service (procedure) basis to an average visit basis will require education for managers, staff, and boards. As the example above illustrates, you should not look at one individual patient. The concept of RHC/FQHC cost-based reimbursement is that over the course of a year, your revenues will be closer to your actual costs. However payments for individual patient encounters could be higher or lower than traditional Medicare. Each clinic's experience may be different. It is essential that you calculate your estimates using a year's worth of information rather than a window of time that may or may not represent the annual costs of operating the facility.

Financial Disadvantages of Cost Reimbursement

A practice that, under a fee-for-service reimbursement method, offers a large number of high charge/high cost procedures (such as surgery) may find that its current average payment per visit is higher than the example used earlier. In this instance, the advantage of cost reimbursement will be less. The RHC/FQHC payment systems are geared to primary care services typically performed in a physician's office. Cost reimbursement in a high tech specialty practice may have a negligible, or even negative, effect on practice revenue.

A general rule of thumb for this type of procedure oriented practice is that, if the average payment for Medicare visits is close to the average payment for all other payer types combined, or the AIRR cap, it is likely that cost-based reimbursement will not provide an appreciable increase in patient revenue.

A Note of Caution

Although not a disadvantage, a practice receiving cost-based reimbursement needs to closely monitor costs throughout the year. A practice converting to RHC or FQHC status will be required to submit a budget reflecting assumptions regarding costs and visits. This information will be reviewed for reasonableness by the Medicare fiscal intermediary and then used to calculate the reimbursement rate for the upcoming fiscal year. It is imperative that such a budget reflect reality as closely as possible in order to make certain that cash flow is adequate, on one hand, and that large liabilities are not being accrued, on the other. The RHC and FQHC programs conduct a year end reconciliation of cost reimbursement, referred to as the cost settlement. If the AIRR is too low and does not reflect reasonable costs during the year, the practice will receive a year end payment. The practice also will likely experience cash flow difficulties. If the rate, based on budget projections, is too high, the practice can end the year having to pay back Medicare. Not only must original rate estimates be as accurate as possible, the rate must be monitored periodically to ensure it is still appropriate. A practice should establish accounting procedures that can accrue ongoing cost reimbursement adjustments based on projected cost reimbursement rates.

Chapter 3

Overview of RHC and FQHC Programs

Comparison of Basic Eligibility Criteria		
Criteria	Rural Health Clinic	Federally Qualified Health Center
Location	Non-urbanized Area	N/A
Shortage Area	MUA, HPSA or Governor Designated Shortage Area	MUA or MUP
Corporate Structure	Unincorporated, public, nonprofit or for profit	Tax-exempt nonprofit or public.
Board of Directors	N/A	Required
Clinical Staffing	MLP required at least 50% of the time the clinic is open	No specific requirements.

Location

An RHC must be located in an area defined by the U.S. Department of Commerce, Census Bureau as non-urbanized. The Census Bureau definition of a non-urbanized area is an area that is outside of an urbanized area. An urbanized area is defined as, “A densely settled territory that contains 50,000 or more people.”

Additional information regarding the definition of urbanized area that is used for location determinations under the RHC program can be found at <http://www.census.gov>; however, the final determination regarding location eligibility is made by the Centers for Medicare and Medicaid Services (CMS) Regional Offices.

The FQHC program bases the distinction between urban and rural on whether or not the area in which a clinic is located is part of a Metropolitan Statistical Area (MSA). An FQHC may be located in either an urban or rural area. A rural area is one which is outside of an MSA. The importance of whether a clinic is designated urban or rural is due to the difference in payment caps that exist for rural versus urban FQHCs.

Shortage Area Designation

Both the RHC and FQHC programs require a shortage area designation, also known as a designation of underservice. A practice is eligible for initial RHC certification if it is located in an area “currently” designated as a Medically Underserved Area (MUA) or Health Professional Shortage Area (HPSA) - either by population or geographic area or location. In addition, governors are allowed to designate areas with a shortage of personal health services through the use of statewide shortage designation plans approved by HRSA’s Bureau of Health Professions (BHPr). In order for a shortage area designation to be considered “current” it cannot be more than 3 years old. Therefore, if you are pursuing initial RHC designation in 2006, the shortage area designation must have been reviewed and approved within the previous 3 years (2003, 2004, and 2005). If the designation is more than 3 years old, the application for RHC status cannot be processed.

An FQHC must be located, as appropriate, to make services accessible to the residents of a designated MUA or Medically Underserved Population (MUP). Location in a HPSA or governor designated shortage area does not meet the shortage area requirement for the FQHC program. Look-Alikes may serve a whole or partial MUA/MUP so long as it demonstrates that it serves the neediest population in the service area or addresses gaps in services and/or health disparities.

A practice should verify the shortage area designation with State officials. Complete information regarding currently designated areas and eligibility criteria is available from BHPr at <http://www.bhpr.hrsa.gov> or by contacting:

U.S. Department of Health and Human Services
Health Resources and Services Administration
Bureau of Health Professions
Division of Shortage Designation
5600 Fishers Lane
Parklawn Building, Room 8C-26
Rockville, MD 20857

The Health Care Safety Net Amendments of 2002 authorized a new HPSA facility designation for both RHCs and FQHCs. Facility HPSA status allows a clinic to participate in the National Health Service Corps program; however, the facility HPSA designation does not meet the shortage areas requirements for either the RHC or FQHC program.

In order for RHCs and FQHCs to be eligible for a HPSA facility designation, the clinic or center must agree to certain principles. The entity shall:

- Not deny requested health care services, and shall not discriminate in the provision of services, to an individual who is unable to pay for services or whose services are paid by the Medicare, Medicaid, or State Children's Health Insurance Program (SCHIP);
- Prepare a schedule of fees consistent with locally prevailing rates or charges;
- Prepare a corresponding schedule of discounts (including waivers) to be applied to such fees or payments, with adjustments made on the basis of the patient's ability to pay;
- Make every reasonable effort to secure from patients the fees and payments for services, and fees should be sufficiently discounted in accordance with the established schedule of discounts;
- Accept assignment for Medicare beneficiaries and shall enter into agreements with agencies administering Medicaid and SCHIP, to ensure coverage of beneficiaries of these programs; and
- Take reasonable and appropriate steps to collect all payments due for services.

This is a voluntary program. If the RHC or FQHC agrees to the above requirements, the clinic or center will receive a HPSA facility designation for 6 years. Look-Alikes receive the HPSA facility designation automatically once they are certified by CMS.

Corporate Structure

Nonprofit and for profit corporations, public agencies, sole proprietorships, and partnerships are eligible for RHC status.

FQHC status is limited to nonprofit, tax exempt corporations and public agencies. HRSA's Bureau of Primary Health Care (BPHC) defines tax exempt as 501(c)(3) status. Look-Alikes cannot be owned, controlled or operated by another entity.

Board of Directors

The RHC program does not have any requirements related to boards of directors.

FQHC status is restricted to nonprofit corporations and public agencies. Therefore, a board of directors that meets specific criteria, as described in the governance section of this chapter, is required.

Clinical Staffing Requirements

An RHC is required to employ a mid-level provider (MLP) at least 50 percent of the time the practice is open to see patients.

FQHCs do not have specific requirements related to MLP staffing, although they are permitted to use MLP staffing as a component of their clinic staffing where appropriate.

Required Scope of Services

Comparison of Required Scope of Services		
Criteria	Rural Health Clinic	Federally Qualified Health Center
Primary Health Care Services	Required	Required
Primary Care for All Life-cycle Ages	Not Required	Required on-site or under arrangement
Basic Lab	Six specified tests required on-site, others required on-site or under arrangement	Required on-site or under arrangement
Emergency Care	First response capabilities required	Required on-site or under arrangement
Radiological Services	Required on-site or under arrangement	Required on-site or under arrangement
Pharmacy	Not Required	Required on-site or under arrangement
Preventive Health	Not Required	Required on-site or under arrangement
Preventive Dental	Not Required	Required on-site or under arrangement
Transportation	Not Required	Required by the site or under arrangement
Case Management	Not Required	Required on site or under arrangement
Dental Screening for Children	Not Required	Required on site or under arrangement
After Hours Care	Not Required	Required
Hospital/Specialty Care	Required by clinic staff or under arrangement	Required by clinic staff or under arrangement

Primary Health Services

The provision of primary health care is required in both programs. Primary health care services for the purposes of these programs are defined as the treatment of acute or chronic medical problems which usually bring a patient to a physician's office.

Primary Care for All Lifecycles

An RHC may be any primary care practice, (e.g. family practice, pediatric, obstetric/gynecology, or internal medicine). An RHC can include specialty services, as long as the RHC can document that it is primarily in the business of delivering primary care services.

An FQHC must provide primary care for all life-cycle ages. Therefore, primary care specialty practices (such as pediatrics or geriatrics) are not eligible for FQHC status, unless they provide for primary care for all life-cycles through contract or formal referral arrangements with accountability to the FQHC.

Basic Lab Services

An RHC is required to provide the following minimum lab services on site:

- Chemical examination of urine by stick or tablet
- Hemoglobin or hematocrit
- Blood sugar
- Examination of stool specimens for occult blood
- Pregnancy tests
- Primary cultures for transmittal to a certified lab

If the RHC performs only these six tests, it may obtain a waiver certificate from the regional Clinical Laboratory Improvement Act (CLIA) office. If an RHC provides other tests on site, it will have to comply with CLIA requirements for the lab services actually delivered.

There are no specific requirements for lab services that must be provided on site for FQHCs. Both programs require that complete lab services be available through arrangements.

Emergency Care Services

RHCs are required to provide medical emergency procedures as a first response to common life threatening injuries and acute illnesses. The definition of first response is that service commonly provided in a physician office.

FQHCs are required to provide emergency care either on site or through clearly defined arrangements for access to health care for medical emergencies during and after the FQHC's regularly scheduled hours. FQHCs must provide for access to emergency care 24/7.

Radiological Services

Both FQHCs and RHCs are required to provide radiological services on site or through arrangements with other providers.

Pharmacy Services

RHCs are not required to provide pharmacy services, but are not prohibited from providing these services on site.

FQHCs are required to ensure access to pharmacy services, either on site or through arrangements with other providers.

Preventive Health Services

There are no requirements for the provision of preventive health services for RHCs.

FQHCs are required to provide preventive health services on site or through arrangements with other providers. Preventive health services include medical social services, nutritional assessment and referral, preventive health education, children's eye and ear examinations, perinatal services, well child services (including periodic screening), immunizations, and voluntary family planning services.

Preventive Dental Services

There are no requirements for the provision of preventive dental services for RHCs.

FQHCs are required to provide preventive dental services on site or through arrangements with other providers. Preventive dental services are defined as brief examinations of the teeth and gums with referral to a dentist for prophylaxis and treatment.

Transportation Services

There are no requirements for the provision of transportation services for RHCs.

FQHCs are required to provide transportation services, as necessary for adequate patient care, either directly or through arrangements with other transportation service providers.

Case Management Services

There are no requirements for the provision of case management services for RHCs.

FQHCs are required to provide case management services on site or through arrangements with other case management agencies. FQHCs are also required to provide outreach and translation enabling services.

After Hours Coverage

There are no specific requirements for an RHC to directly provide on call coverage, although the RHC must make arrangements for access to care, i.e. referral to a hospital outpatient department.

An FQHC should provide professional coverage when the practice is closed, directly or through an after hours care system.

Hospital/Specialty Care

Both RHCs and FQHCs must either provide or have arrangements with other health care

providers to furnish inpatient hospital services and specialty care.

The RHC program has no requirements for hospital admitting privileges, but a practice must demonstrate that hospital services are available to patients. FQHCs are required to have admitting privileges for physicians in the practice or must document a hospital coverage plan that ensures continuity of care.

Management and Finance

Comparison of Management Criteria		
Criteria	Rural Health Clinic	Federally Qualified Health Center
Evaluation	Required annual evaluation of clinic operations	Required annual evaluation of clinic utilization
Compliance with Civil Rights Act	Required	Assurance required
Written Policies and Procedures	Required	Required
Sliding Fee Scale	Not Required	Required
Initial Application	Application forms and on-site survey	Application narrative and on-site survey (on-site survey is not mandatory for FQHCs or look-alikes at the time of application)
Recertification	On-site survey	Statement of compliance with program requirements
Management and Control Systems	Must demonstrate ability to manage cost-based reimbursement	Must provide written description of systems
Independent Financial Audit	Not Required	Required
Governance	No specific requirements	User-majority board of directors required

Evaluation of Need and Community Impact

RHCs and FQHCs are required to perform an annual evaluation of the total program, including an analysis of the utilization of services and, at least, the number of patients served and volume of services.

In addition, FQHCs must prepare documentation describing the physical boundaries of the area served, the demographics and health needs of the population, available health resources, and the rate of poverty in the area. They must demonstrate a need for services in the community. FQHCs must also demonstrate that the practice is serving those most in need, including low income, uninsured, minorities, pregnant women, elderly, and, where appropriate, migrant or seasonal farm workers and those with special needs. FQHCs must further describe the patient population using its services in numbers of patients and visits (encounters) during the last 12 months by age, sex, race, insurance status, income, and those with special needs.

Compliance with the Civil Rights Act (CRA)

RHCs are required to comply with the CRA in order to participate in Medicaid. If RHC status is chosen only for Medicare, compliance with the CRA is not required.

FQHCs are required to provide assurances that they are in compliance with civil rights legislation.

Written Policies and Procedures

Both RHCs and FQHCs are required to document policies and procedures.

Sliding Fee Scale Discount Based Upon Ability to Pay

RHCs are permitted, but not required, to provide sliding fee reductions to collections. Should an RHC opt to obtain the facility HPSA designation, it would be required to have a sliding fee scale.

FQHCs must utilize a sliding fee scale with varying discounts available based on patient family size and income in accordance with Federal poverty guidelines.

Initial Certification/Designation

An RHC completes application forms and participates in an extensive onsite survey.

An FQHC submits a narrative application describing need and community impact and the methods by which it complies with HRSA program expectations. There is no requirement for an onsite survey. However, HRSA may conduct an onsite survey to confirm compliance with assurances in the application.

CMS will not always survey an FQHC prior to approving agreements for participation in Medicare and Medicaid. However, CMS is responsible for resolving complaints about FQHC compliance with Medicare and Medicaid rules and for determining whether FQHCs meet applicable standards for participation in Medicare and Medicaid after signing the provider participation agreement.

Annual Recertification/Redesignation

RHCs are recertified through an onsite survey on a schedule determined by the State agency responsible for the survey and certification of health care facilities.

FQHCs that are funded under Section 330 of the PHS Act must submit a non-competing continuation application demonstrating performance, progress and attesting to compliance with program rules and regulations on an annual basis. Other FQHCs must attest to compliance with program rules and regulations on an annual basis. Funded FQHCs must also submit a competitive application every five years to demonstrate that they are still the most appropriate entity to receive the Section 330 grant funding. As with other HRSA grantees, FQHCs that receive funding under Section 330 of the PHS Act receive an on-site performance review during each 5-year project period.

Description of Management and Control System

RHCs must include a description of management and control systems in the policies and procedures manual. In addition, an RHC needs to respond to questions from the

intermediary assuring that systems have been established to support cost reimbursement.

FQHCs must provide written evidence of sound management and control systems.

Independent Financial Audit

The FQHC program requires an annual financial audit by an independent certified public accountant. An annual financial audit is not required of RHCs.

Governance

There are no specific requirements regarding governance for RHCs.

FQHCs funded under section 330 of the PHS Act and Look-Alikes (except those that are tribal entities), are required to have an independent governing board that:

- Is comprised of a majority (at least 51%) of individuals (“consumers”) whom are being served by the health center and whom as a group, represent the individuals being served by the health center;
- Meets at least once a month;
- Selects the services to be provided by the health center;
- Schedules the hours during which such services will be provided;
- Approves the health center’s annual budget;
- Approves the selection of a director (Program Director or CEO) for the health center;
- Establishes general policies for the health center, except in the case of a governing board of a public center (a public entity may be allowed to retain the responsibility for establishing general policies i.e. fiscal and personnel policies, for the health center); and
- Approves applications for subsequent grants for the health center.

Health centers that are eligible to apply for a waiver of the governance requirements include:

- Migrant Health Centers funded under section 330(g);
- Health Care for the Homeless Programs, funded under section 330(h);
- Public Housing Primary Care Programs, funded under section 330(i); or
- Any section 330 funded health center serving only a sparsely populated rural area (section 330(p))

Private non-profit or public entities that are community health centers (funded under section 330(e)) not serving a sparsely populated rural are not eligible to request a waiver of any part of the governance requirements regardless of whether they also receive funding under sections 330(g), (h) or (i).

Chapter 4

Waivers

Rural Health Clinic Waivers

Waivers from some RHC requirements are available, although not as many of the requirements can be waived as under the FQHC program. Following is a list of those requirements that can be waived, directly or through grandfathering provisions.

Rural Health Clinic Waivers	
Rural Designation	A facility certified as located in a non-urbanized area which subsequently loses this characteristic may remain designated as an RHC
Shortage Area Designation	A facility certified as located in a shortage area which subsequently loses this designation may remain designated as an RHC
Employment of an MLP	If an existing RHC is experiencing recruiting difficulties, the MLP staffing requirement may be waived for up to one year
On-site Laboratory Services	Ability to perform six specific lab tests on-site, as required by the RHC program, may be waived if prohibited by State law

Federally Qualified Health Center Waivers

FQHCs are required to meet program expectations of the HRSA grant program through which it receives funding. As of the publication of this document, applicants must be able to demonstrate compliance with section 330 of the PHS Act, program expectations and all applicable regulations, within 120 days of grant award.

As of the publication of this document, applicant organizations have 120 days of a grant award to become operational and able to provide service within the community. Specifically, applicants should demonstrate at a minimum, that within 120-days of a grant award, (1) a facility will be operational and ready to begin providing services for the proposed population/community and (2) providers will be available to serve at the health center site(s).

Look-Alikes are expected to be operational and in compliance at the time of application.

Chapter 5

Covered Scope of Services

A basic concept in a discussion of covered services under both the RHC and FQHC programs is the theory of “core” services. The set of services constituting core services was first defined in the Rural Health Clinics Act (Public Law 95-210) in 1977. This set of core services has been expanded by amendments to that Act. As of the date of publication of this manual, the definition is as follows:

- Physician services, including required physician supervision of PAs, NPs, and CNMs
- Services and supplies furnished as incident to physician professional services;
- Services of PAs, NPs and CNMs
- Services of clinical psychologists and clinical social workers (when providing diagnosis and treatment of mental illness)
- Services and supplies furnished as incident to professional services provided by PAs, NPs, CNMs, clinical psychologists, and clinical social workers
- Visiting nurse services on a part time or intermittent basis to homebound patients (limited to areas in which there is a designated shortage of home health agencies).

All RHC/FQHC services must be furnished by providers authorized to provide those services. Services and supplies “incident to” professional services of health care practitioners are those commonly furnished in connection with these professional services, generally furnished in a physician’s office and ordinarily rendered without charge or included in the practice bill, such as ordinary medications and other services and supplies used in patient primary care services. “Incident to” services must be furnished by a clinic employee and must be furnished under the direct, personal supervision of the health care practitioner, meaning that the health care practitioner must be physically present in the building and immediately available for consultation.

RHC and FQHC core services include those services provided in the office, other medical facility, the patient's place of residence (including nursing homes), or elsewhere. Medicare does not recognize care provided in hospitals (either inpatient or outpatient) as RHC or FQHC services to be paid for on the basis of cost. Medicaid coverage of hospital care for both an RHC and FQHC will vary from State to State and may be based upon the PPS rate or some other methodology, depending on the State plan.

Core services are covered for Medicare patients and for Medicaid patients. For example, States may not cover psychologists and Licensed Clinical Social Worker services in the Medicaid plan, but must cover these services when provided by these professionals in an RHC or FQHC because they are core services.

The second type of services commonly referred to are other ambulatory services, often called “other ambis.” Other ambulatory services include non-primary care services such as dental services, pharmaceuticals, and all other services covered by a State Medicaid

plan not included in the core RHC services.

FQHC covered services include the RHC core services, some preventive services delivered to Medicare patients, and other ambulatory services delivered to Medicaid patients not included in the definition of core services.

Medicare and Medicaid services under the RHC and FQHC programs are illustrated below.

RHC/FQHC Covered Services				
<i>Service</i>	<i>RHC</i>		<i>FQHC</i>	
	<i>Medicare</i>	<i>Medicaid</i>	<i>Medicare</i>	<i>Medicaid</i>
<i>Preventive Services</i>				
Preventive Services	Specified Medicare Covered Preventive Services Only	If covered in State Plan	✓	If covered in State Plan
<i>Core Services</i>				
Physician Services	✓	✓	✓	✓
MLP Services	✓	✓	✓	✓
Clinical Psychologist Services	✓	✓	✓	✓
Clinical Social Worker Services	✓	✓	✓	✓
Services and Supplies “Incident to” Covered Services	✓	✓	✓	✓
Visiting Nurse Home Health Services (in designated areas)	✓	✓	✓	✓
<i>Other Services</i>				
Hospital Care		If covered in State Plan		If covered in State Plan
Nursing Home Care	✓	If covered in State Plan	✓	If covered in State Plan
Other Ambulatory Services Included in the State Medicaid Plan		If covered in State Plan		
Diabetes Self-Management Training Services and Medical Nutrition Therapy Services		If covered in State Plan	✓	If covered in State Plan
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)		✓		✓

Preventive Services

Coverage of preventive services under the RHC program is limited to those preventive services normally covered by Medicare or specifically covered in the State’s Medicaid plan. Coverage of FQHC Medicare preventive services is broader than Medicare Part B. The Medicare FQHC regulations provide the following definition:

“Preventive services include medical social services, nutritional assessment and referral, preventive health education, children's eye and ear examinations, prenatal and post partum care, prenatal services, well child care (including periodic screening), immunizations, and voluntary family planning services. Preventive services do not include group or mass information programs or health education classes. Preventive services do include those services included in the U.S. Preventive Services Task Force Report for persons age 65 and older.”

Core Services

The defined RHC services also are covered as FQHC core services. All core services are reimbursed on the basis of cost.

Hospital Care

Medicare excludes hospital inpatient and outpatient services from the list of RHC and FQHC covered services. This exclusion is defined by Medicare and does not affect Medicaid coverage of RHC and FQHC hospital services, which will be State specific.

Nursing Home Care

Prior to January 1, 2005, services provided to RHC and FQHC patients in a nursing home under a Medicare Part A covered stay were generally considered to be bundled in the Medicare Skilled Nursing Facility (SNF) per-diem payment rate and were not separately billable by the RHC or FQHC to Medicare Part A. Effective January 1, 2005, RHCs and FQHCs may separately bill Medicare Part A for services provided to clinic patients in a nursing home under a Medicare Part A covered stay as a RHC or FQHC visit.

Services provided by RHC/FQHC providers to RHC/FQHC patients in a nursing home under a non-Medicare Part A covered stay continue to be billable to Medicare Part A as a RHC/FQHC visit.

Other Ambulatory Services

RHC and FQHC Medicaid reimbursement for other ambulatory services provided for in the State plan can be either paid for under the PPS methodology or some alternative methodology established by the State. If “other ambi” services were covered under the Medicaid AIRR before 2001, then they must be covered under the Medicaid PPS methodology. If the State paid fee-for-service for “other ambi” prior to 2001, then the State can continue to pay fee-for-service. “Other ambi” services furnished by an RHC or FQHC are not covered under the Medicare RHC/FQHC benefit.

Services that may qualify as “other ambis” include case management, social services, transportation, pharmacy, dental, and advanced nursing care.

Diabetes Self-Management Training and Medical Nutrition Therapy Services

The Deficit Reduction Act of 2005 (DRA) amended the Social Security Act (SSA) to add Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) Services to the list of Medicare covered and reimbursed services under the Medicare FQHC benefit. Effective for services furnished on or after January 1, 2006, FQHCs that are certified providers of DSMT and MNT services can receive per visit payments for covered services furnished by registered dietitians or nutrition professionals.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

EPSDT is the preventive health and dental program for Medicaid beneficiaries below age 21. It consists of three service components: screening, diagnosis, and treatment. Children are screened periodically for health and developmental problems. If further evaluation is indicated, the program covers diagnostic tests. If a treatment need is detected by a screen, States are required to provide treatment services deemed medically necessary. As a result of OBRA '89, EPSDT children are entitled to all medically necessary services as long as the service is permitted under Federal Medicaid statutes and regulations.

Contract Services

In determining whether or not services are provided under contract or by an employee, a practice should apply the usual common law rules. In applying these rules, consideration is given, not only to who pays a person's salary and fringe benefits, but also to other factors, including who has hiring and firing authority and who pays FICA taxes and withholds income taxes.

Under current CMS policy, contracted RHC services are allowable only in the case of a physician - either at the RHC site or outside the RHC facility. Physicians who are employees of an RHC or FQHC, or who are compensated under agreement by the RHC or FQHC for providing services to clinic patients, may provide services outside of the clinic site when those services are payable to the practice. A practice may also obtain consultations which may be covered under the RHC or FQHC benefit. For example, a specialist may be paid to provide intermittent services at an RHC/FQHC site, and the RHC/FQHC may be reimbursed on the basis of cost for those visits.

Screening guidelines in determining allowable cost for contracted services state that the cost of contracted services is limited to payments for Medicare physician services under the Medicare Physician Fee Schedule. These guidelines are used to define reasonable costs for a Medicare RHC or FQHC and for a Medicaid RHC. Contracting restrictions for FQHC Medicaid services currently vary from State to State.

All contracted services provided through FQHCs must remain under the governance, administration, clinical management, and quality assurance--including record review--of the FQHC organization. An FQHC must describe these arrangements and provide documentation for any contracted service comprising more than 10 percent of costs. Contracted services which meet these requirements may be considered for FQHC reimbursement; however, referred services are not eligible for FQHC reimbursement.

Chapter 6

Reimbursement

Medicare

Medicare reimbursement for RHCs and FQHCs is similar. Both are based on interim payments of an All Inclusive Reimbursement Rate (AIRR) as determined by a cost report. The only exception to this is that an RHC operated as a provider-based facility by a hospital with fewer than 50 beds is exempt from the per visit payment cap. The reimbursement rate for all RHCs and FQHCs is subject to practitioner productivity standards.

Under both programs, Medicare patients are responsible for 20 percent of the allowable charges, subject to the clinic's sliding fee scale. The patient does not pay 20 percent of the AIRR amount.

Medicaid

As noted previously, Medicaid reimbursement for FQHC and RHC services is based on the clinic's PPS reimbursement rate. States also have the option of developing an alternative payment methodology for Medicaid services. These alternatives are State specific and must be agreed to by the clinic.

Under the RHC program, some State Medicaid plans pay for other ambulatory services in addition to RHC core services. For an RHC that offers other ambulatory services covered under a State plan, Medicaid will pay by one of the following methods:

1. The RHC may be paid for RHC core services and other ambulatory services at the PPS rate if the other ambulatory services were part of the RHCs scope of services prior to 2001 and included in the RHCs cost per visit rate.
2. The RHC may be paid for other ambulatory services at a rate set for **each** service by the State if the other ambulatory services were not part of the RHC's scope of services prior to 2001 or were not included in the RHC cost per visit rate if they were offered by the clinic at that time.
3. The RHC may be paid for dental services on a separate cost per visit basis calculated by Medicaid, based on the cost of providing dental services.

Comparison of Reimbursement Issues

The chart illustrates a comparison of the major reimbursement issues under the RHC and FQHC programs.

Comparison of Reimbursement Issues		
<i>Issue</i>	<i>RHC</i>	<i>FQHC</i>
Reimbursement Rate Cap (2006)		
Medicare	\$72.76	\$112.96 (urban) \$97.13 (rural)
Medicaid	Clinic-specific	Clinic-specific
Medicare Fiscal Intermediary		
Independent Clinics	Varies by region	UGS
Provider-based Clinics	Parent provider's FI	N/A
Cost Report		
Independent Clinics -- Medicare	CMS 222	CMS 222
Independent Clinics -- Medicaid	CMS 222/State Specific	State Specific
Provider Based -- all payers	Section M of parent provider's cost report	N/A
Medicare Cost-Sharing		
Medicare Deductible (2006)	\$124.00 per year	N/A
Medicare Coinsurance	20% of billed charges (sliding fee scale may be used to reduce beneficiary payment based on ability to pay)	20% of billed charges (sliding fee scale must be used to reduce beneficiary payment based on ability to pay)
Baseline Provider Productivity Standard		
Medicare	4,200 visits per physician FTE per year 2,100 visits per MLP FTE per year	4,200 visits per physician FTE per year 2,100 visits per MLP FTE per year
Medicaid	4,200 visits per physician FTE per year 2,100 visits per MLP FTE per year	Varies by State

RHC/FQHC Reimbursement Rate Caps

Under the RHC program, the Medicare reimbursement cap for calendar year 2006 is \$72.76 per covered service visit. Under the FQHC program, the Medicare reimbursement rate cap is different for urban and rural practices. The 2006 urban Medicare reimbursement rate cap is \$112.96 and the rural Medicare reimbursement rate cap is \$97.13. An FQHC with both rural and urban sites will have a blended rate based on the percentage of total visits at the rural and urban sites.

Both the RHC and FQHC Medicare reimbursement rate caps are adjusted annually based on the Medical Economic Index applicable to primary health care practitioner services.

Fiscal Intermediary (FI)

There are four major regional RHC Medicare FIs that serve independent RHCs. Under the FQHC program, there is a single Medicare FI for FQHCs. The provider based RHCs use the host provider's current FI.

Under the Medicare Prescription Drug Improvement, and Modernization Act of 2003 (MMA), Congress mandated changes that will lead to a new system for Medicare claims processing. This initiative, referred to as Medicare Contracting Reform, creates a new Medicare Administrative Contractor (MAC) authority. Under the initiative, Medicare will replace its current claims payment contractors – FIs and carriers – with new contract entities, MACs.

The new MACs will serve as the primary point of contact for the receipt, processing and payment of claims for all providers, including RHC's and FQHCs. The MACs will perform all claims processing operations for both Medicare Part A and Part B. CMS will award 15 primary A/B MACs servicing the majority of all Medicare provider types. CMS has set a timeframe to compete and transition all administrative work to the MACs by October 2009.

RHC/FQHC Cost Reporting

An RHC prepares a cost report (CMS 222) that is submitted to its fiscal intermediary. The Medicare intermediary audits the cost report, determines the rate, and calculates the year end reconciliation based on actual costs, the number of Medicare visits, and payments made to the practice during the year.

The CMS 222 cost report is also used by an FQHC for Medicare. Whether States will continue to request copies of the Medicare cost reports now that clinics and centers are reimbursed under a PPS is up to each individual State. Rate setting, auditing, and year end settlements will be negotiated separately with Medicare and Medicaid.

For both an RHC and FQHC, the Medicare year end reconciliation is computed on the basis of **actual** costs, subject to screens and caps. These actual costs are used to reconcile

costs for the RHC/FQHC cost reporting period. The intermediary compares the total payment due the RHC/FQHC with the total payments made for services furnished during the cost reporting period. A practice that projects costs and then spends less than those projections receives an inflated rate per visit and ends the year owing money to Medicare. A practice that projects costs and then spends in excess of those costs will receive a deflated rate per visit and ends the year with Medicare owing money to the practice.

Equally important to the projection of costs is the projection of visits. Visit activity which is not consistent with the budgeted figure will also affect the year end reconciliation by altering the actual cost per visit, as discussed in the role of RHC/FQHC visits section of the following chapter.

In the first cost reporting year, the payment rate will be tied to the estimated reasonable cost of providing covered services for the practice. This rate is subject to the reimbursement rate cap, based on productivity standards and general tests of reasonableness. In subsequent years, the interim payment rate will be based on the actual reasonable costs of the prior year, unless the practice is projecting a change in costs that will significantly change the rate, such as service expansion. In this case, a projected cost report can be submitted.

Medicare Deductible

Medicare patients are responsible for an annual Part B deductible in each calendar year. For 2006 the Medicare Part B deductible is \$124.00. Under the FQHC program, the Medicare Part B deductible is waived for FQHC services. However, the Medicare patient is required to pay the deductible (subject to a sliding fee) for non-FQHC Medicare covered services. The waiver of the deductible may be available for RHC Medicare patients if the clinic has a sliding fee scale.

Coinsurance

Medicare patients of an RHC or FQHC are responsible for 20 percent of the allowable charge for services rendered. An FQHC must apply a sliding fee discount to the coinsurance, depending on the patient's ability to pay. RHCs are permitted to apply a sliding fee discount to the coinsurance, but are not required to do so.

Baseline Practitioner Productivity Standard

Productivity standards are applied to all RHCs and FQHCs. Health care practitioner productivity is measured as the number of RHC/FQHC visits per full time equivalent (FTE). A full time equivalent is defined as the number of hours per year for which one employee of that type must be compensated to meet the clinic's definition of a full-time employee, or a minimum of 1,600 hours per year. Baseline productivity standards for an RHC and an FQHC are 4,200 annual visits for each 1.0 FTE physician and 2,100 annual visits for each 1.0 FTE MLP. Productivity standards may be combined for a "medical team" if staffing levels at a clinic consists of a combination of physicians and MLPs.

Medicaid FQHC productivity standards are State specific. RHC/FQHC visits and the productivity standard are discussed in more detail later.

Chapter 7

Analysis of the Financial Effect for an Independent RHC/FQHC

The determination of costs and the AIRR are based on the Medicare cost finding principles in 42 CFR, part 413, and the respective RHC and FQHC regulations. The accounting principles are complex and warrant careful study and professional advice. The following is a list of the major elements included in a financial analysis of the effect of cost based reimbursement on practice patient revenue:

- Allowable Costs
- Visits
- RHC/FQHC Visits
- Health Care Practitioner Productivity Screens
- Reimbursement Rate Determination
- Payer Mix
- New Service Effect

Reminder: The Medicare AIRR is calculated by dividing allowable costs by RHC/FQHC visits. The rate is subject to a cap for free-standing RHCs and all FQHCs.

Allowable Costs

Allowable costs are those costs that result from providing covered services, are reasonable in amount, and are necessary for the efficient delivery of those services. Allowable costs include the direct cost center component (i.e. salaries and supplies) of providing the covered services and an allocated portion of overhead (i.e. administration and facility). If a practice provides a non-covered service, the direct and indirect cost of this service is unallowable and is excluded from the calculation of the AIRR.

Overhead Allocation

When calculating the AIRR it is necessary to determine the proportion of the practice overhead that can be included in the allowable costs. The table below presents the most common overhead allocation methodology used in preparing a cost report.

Example of Overhead Allocation Methodology

	Breakdown of Practice Costs			
	Allowable	Non-allowable	Overhead	Total
Direct	\$80,000	\$20,000	\$50,000	\$150,000
Percent of Direct Costs	80%	20%		100%
Overhead Allocation	\$40,000	\$10,000	(\$50,000)	\$0
Total	\$120,000	\$30,000		\$150,000

The steps involved in allocating overhead are as follows:

- 1 Determine the allowable and non-allowable direct service costs and the practice overhead costs, as shown in the *direct line* on the table.
2. Calculate the percentages of allowable and non-allowable direct costs to total costs less overhead costs, as shown in the *percent of direct costs* line.
3. Multiply the overhead cost times each direct cost percentage, as calculated in step 2, to arrive at the overhead allocation amount, as shown in the *overhead allocation* line.
4. Add the allocation of overhead, which was calculated in step 3, to the direct service cost, as shown in the *total* line.

A practice that uses a different method of overhead allocation from that demonstrated above must present the methodology to the fiscal intermediary and negotiate the manner in which the overhead is allocated. For example, other types of overhead allocation methods may utilize the square footage percentage, percent of total salaries, or direct allocation based on employment records, time records, etc. A practice needs to analyze available options to determine which allows the most realistic recovery of costs.

Visits

Definition of a Visit

Medicare defines a visit for both RHC and FQHC programs as, “a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, clinical psychologist, or clinical social worker during which an RHC/FQHC service is rendered.” Multiple encounters with more than one health care practitioner or with the same health care practitioner, which take place on the same day and at a single location, constitute a single visit, except for cases in which the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

If more than one visit occurs in one day, any additional costs for this visit will be recovered through the year end cost settlement, unless a practice is at or above the rate cap for either an RHC or FQHC. This occurs because the costs for the service are included in the numerator of the rate calculation, but there is no corresponding visit in the denominator. This has the effect of increasing the interim reimbursement rate. However, if a practice is at or above the cap, the rate cannot increase.

The Medicaid RHC/FQHC definition of a visit is State specific.

Not all patient encounters are counted as visits. For example, a lab visit, when there is no face-to-face encounter with a covered health care practitioner, does not constitute a visit. These services are considered “incident to” a visit. The bill generated during the face-to-face encounter with a covered health care practitioner includes reimbursement for a portion of incidental services because its costs are included in the AIRR calculation.

The Role of RHC/FQHC Visits in Cost Reimbursement

RHC/FQHC visits play an important role in determining cost reimbursement. The number of visits determines the denominator for the calculation of the AIRR. Either the actual number of visits is used in this calculation or a calculated number of visits, based on minimum productivity.

$$\frac{\text{Allowable Costs}}{\text{RHC/FQHC Visits}} = \text{AIRR}$$

Health Care Practitioner Productivity

Health care practitioner productivity is measured as the number of RHC/FQHC visits per full time employed physician or MLP. Productivity screens are applied only to employed physicians, PA, NPs or CNM and not to other covered practitioners, i.e. psychologists, or to physician services provided under contract. The health care practitioner FTE is determined by calculating the amount of time the health care practitioner is available to deliver patient care. Time spent in areas such as administration is deducted from the patient care FTE.

If the minimum number of visits per FTE is below the Calculated Minimum Standard (CMS) the CMS becomes the denominator for the AIRR; otherwise, the actual number of visits is used. The table below shows how the CMS is calculated and the effect of individual and team standards on the number of visits that will be used to calculate the reimbursement rate.

Standard Calculation	(a) Full Time Equivalent	(b) Actual Visits	(c) Standard Visits per 1.0 FTE	(d) Calculated Min. Standard (CMS) Col. (a) x (c)	(e) Higher of Actual or CMS Visits
Scenario #1	0.8	3,500	4,200	3,360	
Physician	1.0	3,900	2,100	2,100	
PA/NP or CNM					
Medical Team		7,400	6,300	5,460	7,400
Scenario #2	0.8	3,000	4,200	3,360	
Physician	1.0	2,400	2,100	2,100	
PA/NP or CNM					
Medical Team		5,400	6,300	5,460	5,460

Productivity Screen Calculation

The RHC and FQHC cost reports calculate the productivity standard for health care

practitioners as a medical team. The table illustrates a comparison of two scenarios for this calculation.

Physician visits, MLP visits, and medical team visits in column (b) are 3,500; 3,900; and 7,400; respectively, in the first scenario. They are 3,000; 2,400; and 5,400 each in the second. Column (c) lists the minimum productivity standards for one FTE for each type of practitioner. To calculate the minimum standard in column (d) to reflect the actual FTE, multiply column (a) by column (c).

To arrive at the medical team productivity standard in column (d), add calculated standards for physician and PA/NP or CNM actual FTEs.

Scenario #1: The higher of actual or CMS visits is shown in column (e). Since the productivity standard was exceeded, actual visits will be used in the AIRR calculation.

Scenario #2: The actual visits are less than the CMS. As a result, the CMS visits will be used in the AIRR calculation.

A practice that cannot meet the productivity standard will have to use the CMS, thereby lowering the AIRR below actual costs.

All Inclusive Reimbursement Rate (AIRR) Determination

The AIRR is determined by dividing allowable costs by RHC/FQHC visits. The example below provides a comparison of a fee-for-service practice and a cost-based reimbursed practice under the RHC or FQHC program.

	Medicare (25%)	Medicaid (25%)	Other (50%)	Total
Total Visits	3,000	3,000	6,000	12,000
Fee-for-Service Practice Average Payment Per Visit Total Patient Revenue	\$35.00 \$105,000	\$29.00 \$87,000	\$64.78 \$388,680	\$580,680
RHC or FQHC All Inclusive Reimbursement Rate (Also Average Payment for Other) Total Patient Revenue	\$64.78 \$194,340	\$64.78 \$194,340	\$64.78 \$388,680	\$777,360
Increased patient payments under cost-based reimbursement				\$196,680
Percent of increase				33.87%

In this example, the AIRR is \$64.78 for the RHC or FQHC, based on the following ratio where total patient revenue is spent on allowable costs:

Allowable Cost of \$777,360 divided by 12,000 RHC/FQHC Visits = An all inclusive reimbursement rate of \$64.78.

Once all components of cost (allowable direct, unallowable direct, and overhead) have been identified and RHC/FQHC visits have been counted, determining the reimbursement rate for comparison purposes is relatively simple.

The Effect of the Rate Cap

The RHC and FQHC programs include another cost containment device: an upper limit (cap) on the AIRR. For those clinics/centers subject to the cap, if the cost per visit is higher than the AIRR cap, the practice will only receive reimbursement equal to the AIRR for each Medicare visit. In this case, it will not be accurate to predict the amount of Medicare reimbursement strictly as a function of payer mix.

In cases where the allowable cost per visit does not exceed the AIRR cap, an approximation of Medicare reimbursement may be determined by multiplying the number of Medicare visits by the AIRR. You can also use this calculation as a rough estimate of the expected Medicaid PPS per visit payment.

If the actual allowable cost per visit is less than the RHC rate cap there will be minimal financial distinction between RHC and FQHC practices. The choice between the two programs will be based on other considerations, such as waiver of the Medicare deductible, governance, or scope of covered services. A practice evaluating which program provides the best financial opportunities must consider not only the current allowable cost, but expansion plans as well.

If the actual allowable cost per visit is greater than the RHC rate cap, a practice might want to consider FQHC status, but should calculate the financial advantages and weigh them against the other factors discussed throughout this document.

The Effect of the AIRR Cap on the Independent RHC/FQHC

It is important to realize that when a practice converts to RHC or FQHC status it should not expect to receive the AIRR cap amount for Medicare visits. If the average receipt from non-Medicare/Medicaid visits is less than the reimbursement rate cap, it could be detrimental for a practice to increase costs to a point where the cost per visit equals the reimbursement rate cap.

In a practice which has no sources of revenue aside from patient revenue and which does not have excessive non-cash expenses, such as depreciation, it will not be possible to increase the average cost per visit over the average receipt from non-Medicare/Medicaid patients without creating a deficit. The reason for this is that Medicare will support the costs of providing services to their beneficiaries up to the program caps; however, if the other payers do not reimburse the practice for the cost of providing services to the non-Medicare/non-Medicaid beneficiaries, the practice will lose money each time it provides services to these patients. In effect, the average receipt from the non-Medicare and Medicaid patient is the maximum cash cost per visit, or an “invisible cap” on the cost per

visit.

The Effect of Other Revenue Sources on Reimbursement

If a practice has additional sources of revenue which do not require an offset in allowable expenses, it is possible for the invisible cap to increase beyond the average receipt from non-cost reimbursed patients. In essence, the additional revenue supports any reimbursement shortfall that might exist between the average receipt from non-cost reimbursed patients and the AIRR. Examples of such sources of revenue include donations and grants.

In general, grants and donations which are spent on allowable costs generate a return on the grant or donation investment equal to the Medicare and Medicaid payer mix. For example, if an RHC or FQHC receives a grant or donation of \$100,000 and has a Medicare/Medicaid payer mix of 50%, that grant or donation is worth \$150,000 to the RHC/FQHC. This return is realized when, and if, donated funds are spent on allowable costs, which Medicare will reimburse in the same proportion as the payer mix-up to the maximum cost per encounter. Understanding this theory provides the RHC and FQHC a very good tool in soliciting support for fundraising in order to expand services and/or provide care to low income, uninsured patients.

Chapter 8

The Provider-Based Rural Health Clinic

A provider-based RHC or FQHC must satisfy the same certification requirements as an independent RHC/FQHC. However, the facility must meet additional requirements to receive the “provider-based” designation. The requirements will vary depending upon the nature of the parent provider (hospital, nursing home, home health agency).

A “provider-based” clinic is defined by CMS as, “A clinic which is an integral and subordinate part of a hospital, skilled nursing, or home health agency participating in Medicare and which is operated with other departments of the provider under common licensure, governance, and professional supervision.” This means that the clinic is administratively, professionally, and organizationally accountable to the authority, bylaws, and operating decisions of the hospital, skilled nursing facility, or home health agency in the same manner as other departments of the provider.

Per 42 C.F.R. §413.65(n), only FQHCs that were operating as provider-based clinics prior to 1995 and received funds under Section 330 of the PHS Act or were determined by CMS to meet the criteria to be a look-alike clinic are eligible to be certified as provider-based FQHCs. Clinics that do not already have provider-based status as an FQHC are not permitted to receive the designation. Thus, information regarding provider-based FQHCs is not included in this publication.

Licensure

The RHC and the parent provider must be operated under the same license, except in areas where the State requires a separate license or in States where State law does not permit licensure under a single license.

Ownership and Control

The facility seeking provider-based status must be operated under the ownership and control of the parent provider. The following requirements must be met:

- The business enterprise that constitutes the facility must be 100 percent owned by the parent provider;
- The parent provider and the facility seeking status as a RHC must have the same governing body;
- The facility must be operated under the same organizational documents as the parent provider; and
- The parent provider must have final responsibility for administrative decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies (such as fringe benefits/code of conduct), and final approval for medical staff appointments in the facility.

The fact that an RHC is owned by a hospital, skilled nursing facility, or home health agency; is governed by the same board; and has the same administrator as the parent provider does not automatically result in a finding that the RHC is provider-based. For example, the provider board may govern the RHC independent of the parent provider, or the RHC may have policies and procedures which differ from those of the parent provider. Determination of the provider-based status is made by examining the total relationship which exists between the practice and the provider. Policies and procedures, bylaws, board meeting minutes, State licenses, and lines of authority and responsibility are typical forms of documentation which should be used to make the determination of provider-based status.

Administration and Supervision

The reporting relationship between the facility seeking provider-based status and the parent provider must have the same frequency, intensity, and level of accountability that exists in the relationship between the parent provider and one of its departments, as evidenced by compliance with all of the following requirements:

- The facility is under the direct supervision of the parent provider.
- The facility is operated under the same monitoring and oversight by the provider as any other department of the provider, and is operated just as any other department of the provider with regard to supervision and accountability. The facility director or individual responsible for daily operations at the entity must maintain a day-to-day reporting relationship with a manager at the parent provider, and be accountable to the governing body of the parent provider, in the same manner as any department head of the provider.
- The following administrative functions of the facility are integrated with those of the provider where the facility is based:
 - billing services
 - records
 - human resources
 - payroll
 - employee benefit package
 - salary structure
 - purchasing services

Clinical Services

The clinical services of the facility seeking provider-based status and the parent provider are integrated as evidenced by the following:

- Professional staff of the facility has clinical privileges at the parent provider.
- The parent provider maintains the same monitoring and oversight of the facility as it does for any other department of the provider.
- The medical director of the facility seeking provider-based status maintains a (day-to-day) reporting relationship with the chief medical officer or other similar

- official of the parent provider that has the same frequency, intensity and level of accountability as the relationship between the chief medical director of a department of the parent provider and the chief medical officer. The RHC medical director must be under the same type of supervision and accountability as any other director, medical or otherwise, of the parent provider.
- Medical staff committees or other professional committees at the parent provider are responsible for medical activities in the facility including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility seeking provider-based status and the parent provider.
 - Medical records for patients treated in the facility are integrated into a unified retrieval system (or cross reference) of the parent provider.
 - Outpatient services of the facility and the parent provider are integrated, and patients treated at the facility who require further care have full access to all services of the parent provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the parent provider.

Financial Integration

The financial operations of the facility must be fully integrated within the financial system of the parent provider, as evidenced by shared income and expenses between the parent provider and the facility. The costs of the facility are reported in a cost center of the parent provider and the financial status of the facility is incorporated and readily identified in the parent provider's trial balance.

Public Awareness

The facility seeking status as an RHC is held out to the public and other payers as part of the parent provider. When patients enter the provider-based RHC, they are aware that they are entering the parent provider and are billed accordingly.

Location

The RHC and the parent provider are located on the same campus, except when:

- The parent provider is a hospital or Critical Access Hospital (CAH) that is within 35 miles of the RHC;
- The parent provider is a hospital or CAH that is eligible to participate in the 340b drug purchasing program;
- The RHC is otherwise qualified as a provider-based entity of a hospital that is located in a rural area and has fewer than 50 beds; or
- The RHC demonstrates a high level of integration with the parent provider by showing that it meets all of the other provider-based criteria, and demonstrates that it serves the same patient population as the parent provider, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed with

CMS, and for each subsequent 12-month period:

- At least 75 percent of the patients served by the facility reside in the same zip code areas as at least 75 percent of the patients served by the parent provider;
- At least 75 percent of the patients served by the facility who required the type of care furnished by the parent provider received that care from that provider (for example, at least 75 percent of the patients of an RHC seeking provider-based status received inpatient hospital services from the hospital that is the parent provider); or
- If the facility is unable to meet the criteria because it was not in operation during all of the 12-month period, the facility is located in a zip code area included among those that, during all of the 12-month period described in the previous sentence, accounted for at least 75 percent of the patients served by the parent provider.

A facility is not considered to be eligible for provider-based status unless the facility and the parent provider are located in the same State or in an adjacent State, if this is not inconsistent with the law of either State and other criteria are met, including those related to services to the same patient population.

Cost Reporting

A provider-based RHC becomes a department of the host provider organization and, thereby, becomes part of the cost report of the parent provider. When an RHC is part of a hospital, its costs are reported on Schedule M of the parent hospital's cost report.

Payment Mechanism

A provider-based RHC is paid using the identical methodology used to pay an independent RHC. The only difference between the two types of RHCs with regard to payment is that RHCs that are provider-based to a hospital with fewer than 50 beds may request an exemption from the per-visit cap on their payments. RHCs that receive this exemption are paid a per-visit All Inclusive Reimbursement Rate (AIRR) that reflects their full Medicare-allowable costs.

Fiscal Intermediary

A provider-based practice reports costs through the parent provider's cost report and, therefore, will retain the same fiscal intermediary as the parent provider.

Summary

The following table presents a comparison of the independent and provider based RHC or FQHC with a provider based outpatient department.

Clinic Type	Reimbursement Basis		Cost Containment Mechanism	Cash Flow Mechanism
	Physician (Professional) Component	Facility Component		
Hospital Outpatient Clinic	Physician Fee Schedule	Outpatient Prospective Payment System (OPPS)	Set rates for all services	Individual Claims Submission and Payment
Provider Based RHC	100% of Reasonable Costs		Provider Productivity Screens.	All Inclusive Reimbursement Rate and Year End Cost Settlement
Independent RHC or FQHC	100% of Reasonable Cost		Provider Productivity Screens and All Inclusive Reimbursement Rate Caps	All Inclusive Reimbursement Rate and Year End Cost Settlement

Chapter 9

Other Issues

Dual Certification

It is possible for a practice to be certified as both an RHC and an FQHC, although only one payer status is available for either Medicare or Medicaid. The most likely option for dual certification will be RHC status for Medicare and FQHC status for Medicaid. Although working through the mechanics of such dual certification with State licensing agencies, the regional CMS office, and the state Medicaid agency may require additional effort on the part of the clinic and agencies, there is nothing in either statute that would prohibit a practice from requesting dual certification.

Medicaid Managed Care

Medicaid programs often link managed care with capitated payments, under which a fixed sum is paid for a specified set of services. Medicaid managed care plans are required to pay RHCs and FQHCs at rates comparable to the rates paid to other providers of similar services. States are then required to “wrap-around” that payment by making additional payments (if necessary) to the FQHC/RHC in an amount equal to the difference between the amount paid by the managed care plan and the amount of the clinic’s Medicaid PPS rate. This protection in the managed care environment may prove to be one of the strongest incentives for obtaining RHC or FQHC status. As a State obtains waivers from Federal Medicaid requirements, it is important for RHCs/FQHCs to monitor how those waivers will affect its fiscal viability.

Medicare Managed Care (Medicare Advantage)

Each FQHC and RHC must negotiate and sign individual contracts with the Medicare Advantage plans in which they wish to participate as a provider. There are no restrictions on the rates that Medicare Advantage plans must pay to RHCs. RHCs are responsible for negotiating rates that they believe are appropriate given their payer mix, local market for health care services and managed care penetration. There are rules that govern the payment rates for FQHCs that choose to contract with Medicare Advantage plans. Medicare Advantage plans are required to pay FQHCs with which they contract for services at rates comparable to the rates that they pay other providers for similar services. FQHCs are then entitled to receive “wrap-around” payments from the Medicare program equal to the difference between the plan payment amount and their All Inclusive Reimbursement Rate (AIRR).

FTCA Coverage

FQHCs funded under Section 330 of the PHS Act are eligible for coverage under the Federal Tort Claims Act (FTCA). This may eliminate the need for health professional employed by an FQHC to obtain private malpractice insurance coverage. If the employer

typically pays for this malpractice insurance, this represents a significant savings to the FQHC. RHCs are not eligible for FTCA coverage. In recent years as malpractice insurance premiums have gone up dramatically, some RHCs have explored FQHC status simply because of the ability to obtain FTCA coverage for their health professionals. Note that Look-Alike clinics are not eligible for coverage under FTCA.

Access to the 340B Program

FQHCs are eligible to participate in the PHS 340B Drug Pricing Program (340B). This program limits the costs of drugs purchased by entities authorized to participate in the program. Participation in the 340B program means FQHCs are able to realize substantial savings on the purchase of outpatient drugs for use by or sale to their patients. On average, 340B drugs cost 20 to 40 percent of the Average Wholesale Price (AWP) of the same drugs if purchased on the open market. RHCs are not eligible to participate in the 340b program.

Conclusion

Cost-based and PPS reimbursement through the RHC and FQHC programs present an opportunity for enhanced services in underserved areas. While these opportunities are attractive, there needs to be recognition of the effect that conversion to cost-based or PPS reimbursement will have on clinic operations and staff. Billing systems will need to be modified, as will data collection systems. The clinic's financial manager and other staff will need to be trained, as will the accounting firm that works with the practice. Board members will have to be educated to modify the way they monitor the fiscal stability and conduct the long range planning for the practice.

The effect of cost-based and PPS reimbursement on a particular RHC or FQHC will be determined by a combination of several circumstances. These include total practice costs, spending patterns, the total number of visits, the percentage of Medicaid and Medicare visits, and the receipt of grant funds and/or donations. The effect on any individual practice can rarely be determined by a review of general theories. A financial and programmatic analysis will most often be necessary to project the changes to the organization and its revenues.

Appendix A

Acronyms

AIRR	All Inclusive Reimbursement Rate
AWP	Average Wholesale Price
BBA	Balanced Budget Act of 1997
BIPA	Benefits Improvement and Protection Act of 2000
BPHC	Bureau of Primary Health Care
CAH	Critical Access Hospital
CHC	Community Health Center
CMS	Centers for Medicare and Medicaid Services
CMS	Calculated Minimum Standard
CNM	Certified Nurse Midwife
DRA	Deficit Reduction Act of 2005
DSMT	Diabetes Self-Management Training
EPSDT	Early and Periodic Sreening, Diagosis and Treatment
FI	Fiscal Intermediary
FQHC	Federally Qualified Health Center
FTCA	Federal Tort Claims Act
FTE	Full Time Equivalent
HC	Health Center
HCH	Health Care for the Homeless
HHS	U.S. Department of Health and Human Services
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
LCC	Lower of Costs or Charges
MHC	Migrant Health Center
MLP	Mid-Level Provider
MMA	Medicare Prescripton Drug Improvement and Modernization Act of 2003
MNT	Medical Nutrition Therapy Services
MSA	Metropolitan Statistical Area
MUA	Medically Underserved Area
MUP	Medically Underserved Population
NP	Nurse Practitioner
OBRA 89	Omnibus Budget Reconciliation Act of 1989
OBRA 90	Omnibus Budget Reconciliation Act of 1990
ORHP	Office of Rural Health Policy
PA	Physician Assistant
PHPC	Public Housing Primary Care
PHS	Public Health Service
PPS	Prospective Payment System
RHC	Rural Health Clinic
SCHIP	State Children’s Health Insurance Program
UGS	United Government Services

Appendix B

Additional Resources

U.S. Department of Health and Human Services (DHHS)

<http://www.hhs.gov>

DHHS, Centers for Medicare and Medicaid Services (CMS)

<http://www.cms.hhs.gov>

DHHS, Health Resources and Services Administration (HRSA)

<http://www.hrsa.gov>

DHHS, HRSA, Bureau of Primary Health Care (BPHC)

<http://www.bphc.hrsa.gov>

DHHS, HRSA, Bureau of Health Professions (BHPH)

<http://www.bphr.hrsa.gov>

DHHS, HRSA, Office of Rural Health Policy (ORHP)

<http://ruralhealth.hrsa.gov>

U.S. Department of Commerce, Census Bureau

<http://www.census.gov>

National Association of Community Health Centers (NACHC)

<http://www.nachc.org>

National Association of Rural Health Clinics (NARHC)

<http://www.narhc.org>

National Organization of State Offices of Rural Health (NOSORH)

<http://www.nosorh.org/groups/nosorh/default.htm>

National Rural Health Association (NRHA)

<http://www.nrharural.org>

Rural Assistance Center (RAC)

<http://www.raconline.org>