

Medicaid Payment Policy for Federally Qualified Health Centers

State Medicaid programs are required to cover services furnished by federally qualified health centers (FQHCs), community-based health care providers that receive federal funds from the Health Resources & Services Administration (HRSA) to provide care in underserved areas. FQHC services must include preventive and primary health care services such as family and internal medicine, pediatrics, obstetrics and gynecology, diagnostic laboratory and radiology services, emergency services, preventive dental services, and pharmacy services (in certain centers). FQHCs may also provide other outpatient services such as vision services, behavioral health services, and other ambulatory care services included in the state's Medicaid plan. FQHCs also provide some non-medical services, such as language interpretation services and health education.

In fiscal year (FY) 2016, Medicaid spent \$4.5 billion for health center services provided to Medicaid beneficiaries (MACPAC 2017a).¹ Medicaid is the largest source of revenue for FQHCs, accounting for about 44 percent nationally in FY 2015 (KFF 2017). In calendar year 2016, nearly half (49.2 percent) of FQHC patients had Medicaid as their primary source of insurance (HRSA 2016).²

This brief describes the methods used to set Medicaid payment rates for FQHCs, including examples of alternative payment methods. It also highlights current policy issues related to Medicaid FQHC payment.

The Role of FQHCs in Medicaid

Federally qualified health centers are health centers that receive federal grant funding under Section 330 of the Public Health Service Act.³ These organizations focus on providing comprehensive and affordable primary and preventive health care to individuals with low-incomes who are uninsured and underinsured, as well as other vulnerable populations.⁴ Health centers target services to fit the needs and priorities of their communities, and often provide services that help their patients access medical care, such as transportation, and language interpretation assistance.⁵

Nearly 1,400 grantee health centers serve more than 25 million patients in over 10,000 delivery sites (HRSA 2017). Consistent with FQHCs' mission of serving vulnerable populations, 92 percent of their patients have incomes below 200 percent of the federal poverty level (FPL) (HRSA 2016).⁶ Close to one-quarter (22.6 percent) of health center patients identify as African American, and 35.4 percent identify as Hispanic or Latino (HRSA 2016).⁷



FQHC services

FQHCs must provide basic health services including primary and preventive care, and enabling services to help patients access care such as outreach, transportation, and language interpretation services.⁸ Some centers also provide physician-administered drugs and outpatient prescription drugs. FQHCs must also provide referrals to off-site specialists including mental health and substance use disorder providers. Services such as behavioral health and treatment for substance use disorders, environmental health, and occupation-related health services may be provided by an FQHC where appropriate to meet the health needs of the population served.

Section 1905(a)(2) of the Social Security Act (the Act) specifies that state Medicaid programs must cover FQHC services and any other ambulatory services offered by an FQHC and which are otherwise included in the Medicaid state plan. The rationale for this requirement is to ensure that federal grant dollars are used to cover the costs of the uninsured and medically underserved instead of subsidizing costs for the Medicaid population (NACHC 2016a).⁹

Medicaid Payment for FQHCs

Medicaid payment rules for FQHCs differ from those for other providers because federal law has established a prospective payment system (PPS) prescribing how FQHCs are to be paid for each encounter or visit. States also may implement an alternative method (APM) that pays the same or more than the federal PPS.

Prospective payment system

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (P.L. 106-554) created the PPS for Medicaid FQHC and rural health clinic (RHC) payments in all states and territories.¹⁰ The State Children's Health Insurance Program (CHIP) was required to adopt this payment method under the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3). Prior to the PPS, FQHCs and RHCs were paid based on their costs.

FQHC prospective payment rates are determined based on two key components:

- **PPS base rate:** States were required to set a per-visit payment rate for each FQHC based on the average of the center's costs incurred during fiscal years (FYs) 1999 and FY 2000. The base rate was composed of the allowable capital cost per visit and the lesser of the allowable operating cost per visit or the peer group operating cost ceiling per visit.

Payment rates for FQHCs that qualified for Medicaid payments after FY 2001 are based at either the average of other clinics in the same or adjacent areas or through cost reporting.

- **Adjustments:** States use the Medicare Economic Index (MEI), a measure of medical practice cost inflation, to adjust payment rates annually. States are also required to adjust FQHC payment rates for each clinic to reflect changes in scope of services included in the encounter rate. For example, the



state could adjust an FQHC's encounter fee if an FQHC increased its capacity, either by improving facilities, building additional facilities, or providing additional Medicaid-eligible services that were not covered or provided when the base rate was determined.

Encounter fees generally cover all qualified services provided during a visit, unlike a visit in a physician's office in which each service is billed individually. For example, a face-to-face exam with a physician, screening by a nurse, and lab tests that occurred in one visit would all be paid for by the single encounter fee.

States can exercise some flexibility within the federal FQHC PPS. For example, states can define which services are included in the encounter or visit, and can establish limits on how many encounters an FQHC can bill per member per day. Hawaii allows FQHCs to bill for one medical or optometry visit, one behavioral health visit and one dental visit per day, while Oklahoma allows for more than one visit per day within the same category of service as long as it is for an unrelated diagnosis (NACHC 2012). States may also limit the number of reimbursable visits in a year or require prior authorization for visits that exceed the number allowed.

In certain situations, FQHCs may file a claim for both a PPS encounter and for additional Medicaid-covered services that are not included in the PPS rate. Some FQHCs may pay for additional or ancillary services using a different methodology. Delaware, for example uses the PPS methodology for primary care costs, a cost-based methodology for administrative costs, and the actual acquisition costs for long-acting reversible contraceptives (CMS 2017).

Some states pay the same encounter rate regardless of service type, but others differentiate between medical, behavioral health, and dental services. Some FQHCs cover services not provided in most physicians' offices (e.g., transportation or other enabling services), so the PPS rate can be higher relative to primary care services provided in a physician's office.

Alternative payment methodology

States have the option to use an APM, provided that the health center agrees to the method and that the alternative method pays at least what the health center would have received under the PPS.¹¹ If total payments under the APM are less than what would have been paid under the PPS rate, the state must pay the difference to the FQHC. In 2016, states paid more than \$536 million in APM supplemental payments, about 12 percent of all Medicaid payments to FQHCs (HRSA 2016, MACPAC 2017b).¹²

States vary in their use of PPS and APMs. A 2014 survey found that 24 states reported using PPS only, while 14 states used an APM, and 9 states used both (NACHC 2014). States can use multiple APMs within the state, within a health center for different services, or for services provided by different providers (e.g., primary care providers, behavioral health providers, or dentists). In the survey referenced above, among the states that used an APM, most used either a cost-based methodology similar to that used prior to the PPS, or a modified version of the PPS rate that calculates a new base rate by using different base years or an otherwise updated formula (NACHC 2014).



States use a variety of APMs. Some make modest adjustments to the typical PPS rate, such as adjustments to the base rate or inflation factor. For example, Kansas has an approved APM that rebased PPS rates using 2009 and 2010 data. Some states and FQHCs have pursued PPS alternatives as a part of broader efforts to transform how health care is delivered (Shin et al. 2016). For example:

- Colorado pays FQHCs the midpoint between the PPS and the alternative payment. The alternative payment is the lesser of the current year encounter rate as reported in annual audited cost reports, or the clinic's base encounter rate inflated annually by the MEI. The base encounter rate is the inflated weighted average of encounter rate for the three years immediately preceding a rebasing. A new base encounter rate is established every three years (JSI 2011).
- Oregon implemented a new payment method in 2013. The state pays FQHCs a per-member per-month (PMPM) payment, based on each health center's historical PPS payments, for each attributed Medicaid enrollee, whether or not the person seeks care. Each center establishes a capped rate for estimated wraparound payments for managed care patients (described below). Such payments are for primary care services; specialty mental health services, dental services, and obstetrical services are paid at a center's PPS rate (NACHC 2016b).
- Minnesota uses two basic alternative payment methodologies: 1) 100 percent of cost, using the pre-PPS cost rate methodology to settle the year's claims, and 2) the PPS rate plus 2 percent to cover the tax obligations of MinnesotaCare, the publicly subsidized program for uninsured residents who are not eligible for Medicaid (MN DHS 2016).

Managed care

Managed care organizations (MCOs) must ensure that FQHC services are accessible to Medicaid members to the same extent as such services are accessible under fee for service (§ 1903(m)(1)(A)(i) of the Act). In 2016, 59.3 percent of FQHCs' Medicaid revenue was from Medicaid managed care payments (HRSA 2016).¹³

FQHCs that participate in managed care networks must also receive payment that is at least equal to the PPS per visit payment rate floor in the aggregate (§§ 1902(bb)(5) and 1903(m)(2)(A)(ix) of the Act). Managed care network plans have broad flexibility in how they pay for FQHC services and are not required to use either the PPS rates paid under fee-for-service or cost-based methods, although plans are required to pay FQHCs at least what they would pay non-FQHC providers in their network for the same medical services (§ 1903(m)(2)(A)(ix) of the Act).

When total MCO payments to an FQHC are less than what the center would have been paid under the PPS or APM amount, the state Medicaid agency must pay the difference (§ 1902(bb)(5) of the Act, GAO 2005, CMS 2001). This payment is called a supplemental, or wraparound, payment. The state must pay up to the PPS rate irrespective of financial incentives or disincentives employed by the managed care entity. In 2016, FQHCs received \$2.4 billion in net Medicaid retroactive managed care supplemental payments (HRSA 2016).¹⁴

Some states require that plans make full PPS payments to FQHCs so as to avoid the need to make supplemental payments.¹⁵ States and FQHCs may prefer this approach because it reduces administrative



burden and decreases potential delays in receiving supplemental payments. On the other hand, some FQHCs have expressed concern that discrepancies between how states and MCOs calculate the PPS rate may result in lower payments than the PPS rate (NACHC 2015).

Other states use alternative payment methods within their managed care contracts. California, for example, is developing a program that allows Medicaid managed care plans to make a PMPM payment for Medicaid enrollees who are assigned to the FQHC as their primary care provider. This will replace the prior method under which FQHCs billed Medicaid plans for encounters and billed the state for wraparound payments.¹⁶ The capitation payment is based on all of the Medicaid-eligible services each site provides to Medicaid enrollees that may have previously been paid for through wraparound payments. The monthly payment cannot be less than the site's per-visit PPS rate. This method is intended to reduce administrative burden for both FQHCs and the state and alleviate cash flow concerns for FQHCs, while providing flexibility to FQHCs to provide non-traditional services (CPCA and CAPH, 2016).¹⁷

Payment Process

FQHC payment is triggered when a health center submits a claim to the state or managed care plan. The frequency of FQHC payments varies under alternative payment methods based on the specific methodology; some states pay FQHCs per visit, while others pay monthly or quarterly. Reconciliation to determine whether supplemental payments are necessary generally occurs quarterly.

Payment Policy Issues

States have argued for more flexibility in setting payments to FQHCs. Recently, they have pointed to PPS rate limits as barrier to incorporating FQHCs into value-based payment initiatives. Health center administrators maintain that certain policies are appropriate to recognize the costs of providing care to Medicaid beneficiaries and ensuring the financial stability of key safety-net providers. Their concerns focus primarily on issues such as rebasing outdated cost bases, using alternative inflation benchmarks, and testing different approaches to administration of wraparound payments.

Endnotes

¹ The \$4.5 billion that Medicaid spent on FQHC services in FY 2016 includes both fee-for-service payments as well as wrap around payments for FQHC services provided under Medicaid managed care arrangements.

² Percent of FQHC patients with Medicaid as their primary source of insurance is from HRSA program grantee data, full 2016 national report Table 4: Selected patient characteristics line 8 (HRSA 2016).

³ Health centers apply for the FQHC designation through the Bureau of Primary Health Care within HRSA. FQHCs can receive federal grant funding (up to \$650,000 for the first year, decreasing in subsequent years) and medical malpractice coverage for the organization, employees, and eligible contractors. Most community health centers must be in either a Health Professional Shortage Area (HPSA) or a Medically Underserved area, as defined by HRSA to meet certification requirements.



FQHCs must report administrative, clinical, and other information to the Bureau of Primary Health Care. They are also required to make services accessible to community residents by providing transportation services as necessary, case management, outreach and enabling services (for example, language interpretation) and professional coverage when the health center is closed.

⁴ By law, health centers may only charge a nominal fee to individuals whose incomes are below the federal poverty level. Individuals whose incomes are between 101 and 200 percent of the federal poverty level must be charged using a sliding fee scale with varying discounts available based on income and family size. FQHCs, however, must provide services without regard to a patient's ability to pay. FQHC look-alikes (see below) and rural health clinics (RHCs), which do not receive federal grant funding, are not subject to this requirement.

⁵ Certain health centers that meet the eligibility requirements to qualify as an FQHC, but do not receive HRSA grant funding, are known as FQHC look-alikes. In 2015, there were about 100 FQHC look-alikes nationwide (KFF 2017). FQHC look-alikes must comply with HRSA requirements for health centers.

⁶ Percent of patients with low income is from HRSA program grantee data, full 2016 national report Table 4: Selected patient characteristics, lines 1, 2, and 3 (HRSA 2016).

⁷ Race and ethnicity data is from HRSA program grantee data, full 2016 national report Table 3B: Patients by Hispanic or Latino ethnicity/race/language lines 3 and 9 (HRSA 2016).

⁸ Basic health services provided by FQHCs include general primary care, family and internal medicine, prenatal and perinatal services, preventive dental services, pediatric screenings, and emergency medical services.

⁹ *Three Lower Counties Community Health Services, Incorporated v. Maryland*, 498 F.3d 294 (4th Cir. 2007).

¹⁰ RHCs are a separate type of federally recognized health center. RHCs are required to be located in non-urban medically underserved areas, including areas designated as medically underserved by a state governor. They have unique provider staffing requirements. These clinics are not required to provide the full array of primary care, mental health, oral care and other services for all ages, nor are they required to provide after-hours care.

¹¹ States typically implement alternative payment methods for FQHCs through a state plan amendment. State plan amendments must be approved by CMS.

¹² Medicaid APM supplemental payments are calculated as the net retroactive settlements for Medicaid non-managed care payments as cited in the HRSA program grantee data, full national report Table 9D: Patient Related Revenue (HRSA 2016).

¹³ Revenue from Medicaid managed care is calculated as the sum of lines 2a and 2b within the HRSA program grantee data, full 2016 national report Table 9D: Patient Related Revenue, Collections header, percent of payer column (HRSA 2016).

¹⁴ Medicaid managed care supplemental payments are calculated as the sum of the net retroactive settlements for capitated managed care payments and fee-for-service managed care payments as cited in the HRSA program grantee data, full national report Table 9D: Patient Related Revenue lines 2a and 2b (HRSA 2016).

¹⁵ States must receive CMS approval to amend their Medicaid state plan to require Medicaid managed care plans to make full PPS payments to FQHC (CMS 2016a).

¹⁶ Individuals who are dually eligible for both Medicare and Medicaid, and non-assigned Medi-Cal beneficiaries will continue to be paid under the PPS system (CPCA and CAPH 2016).



¹⁷ Non-traditional services include primary care and behavioral health visits on the same day, telemedicine (including email and telephone encounters), group visits, community health worker contacts, and case management and care coordination services (CPCA and CAPH 2016).

References

California Primary Care Association and California Association of Public Hospitals and Health Systems (CPCA and CAPH). 2016. *California's FQHC payment reform pilot*. <http://caph.org/priorities/federal-policy/fqhc-issues/>

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2017. Attachment to the Delaware Medicaid state plan. June 26, 2017. Baltimore, MD: CMS. <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/DE/DE-17-003.pdf>

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016a. Letter from Vikki Wachino to state health officials regarding "FQHC and RHC supplemental payment requirements and FQHC, RHC, and FBC network sufficiency under Medicaid and CHIP managed care." April 26, 2016. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd16006.pdf>

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016b. Medicare program; revisions to payment policies under the physician fee schedule and other revisions to Part B for CY 2017; Medicare Advantage bid pricing data release; Medicare Advantage and Part D medical loss ratio data release; Medicare Advantage provider network requirements; Expansion of Medicare diabetes prevention program model; Medicare shared savings program requirements. Final rule. *Federal Register* 81, no. 220 (November 16): 80170–80562. <https://www.gpo.gov/fdsys/pkg/FR-2016-11-15/pdf/2016-26668.pdf>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2001. Letter from Richard Chambers to associate regional administrators regarding "Benefits Improvement and Protection Act (BIPA) of 2000, Section 702, prospective payment system (PPS) for Federally Qualified Health centers (FQHC) and Rural Health Clinics (RHC) — action." September 12, 2001. <http://nachc.org/wp-content/uploads/2015/11/PPS-Q-As-2001.pdf>

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2000. Letter from Timothy M. Westmoreland to state Medicaid directors regarding "policy regarding FQHCs/RHCs." September 27, 2000. <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd092700.pdf>

Health Care Financing Administration (HCFA), U.S. Department of Health and Human Services. 1998. Letter from to state Medicaid directors regarding "changes in Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) requirements stemming from BBA." April 20, 1998. <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD042098.pdf>

Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services. 2017. *Health center program fact sheet*. August 2017. <https://www.bphc.hrsa.gov/about/healthcenterfactsheet.pdf>

Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services. 2016. Program grantee data. *2016 health center data*. <https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2016&state=&fd=>



JSI Research & Training Institute, Inc. (JSI). 2011. *Federally Qualified Health Center/Rural Health Clinic prospective payment system plus reimbursement methodology*. Boston, MA: John Snow, Inc.
http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=12200&lid=3

Kaiser Family Foundation (KFF). 2017. *Distribution of revenue by source for federally funded Federally Qualified Health Centers*. Washington, DC: Kaiser Family Foundation. <http://kff.org/other/state-indicator/distribution-of-revenue-by-source-for-federally-funded-federally-qualified-health-centers/?dataView=1¤tTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

Medicaid and CHIP Payment and Access Commission (MACPAC). 2017a. Analysis of CMS-64 Financial Management Report (FMR) data for fiscal year 2016 that were reported by states as of November 2, 2017.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2017b. Analysis of 2016 health center data (patient related revenue data) and CMS-64 Financial Management Report (FMR) data for fiscal year 2016 that were reported by states as of November 2, 2017.

Medicare Economic Index Technical Advisory Panel (MEITAP), U.S. Department of Health and Human Services (HHS). 2012. *Report to the HHS Secretary: Review of the Medicare Economic Index*. Washington, DC: HHS.
<https://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/Downloads/MEI-Review-Report-to-HHS.pdf>

Minnesota Department of Human Services (MN DHS). 2016. Federally Qualified Health Center and Rural Health Clinics. Methodology and payment information.
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_155131

National Association of Community Health Centers (NACHC). 2016a. *Health centers and Medicaid*. Bethesda, MD: National Association of Community Health Centers. http://www.nachc.org/wp-content/uploads/2016/12/Medicaid-FS_12.16.pdf

National Association of Community Health Centers (NACHC). 2016b. *Spotlight on health center payment reform: Oregon alternative payment and advanced care model. December 2016*. <http://www.nachc.org/wp-content/uploads/2016/12/Oregon-FQHC-APM-December-2017.pdf>

National Association of Community Health Centers (NACHC). 2013. *NACHC submits comments on CMS proposed rule on development of Medicare PPS*. November 19, 2013. <http://blogs.nachc.com/policyshop/nachc-submits-comments-on-cms-proposed-rule-on-development-of-medicare-pps/>

National Association of Community Health Centers (NACHC). 2012. Medicaid reimbursement for multiple same-day encounters: Florida's experience. *Emerging issues series*. Washington, DC: NACHC. <http://www.nachc.org/wp-content/uploads/2015/11/Medicaid-Same-Day-Visits-FINAL.pdf>

National Association of Community Health Centers (NACHC). 2011. *Emerging issues in the FQHC prospective payment system*. Washington, DC: NACHC. <http://nachc.org/wp-content/uploads/2015/11/SPR38-Emerging-Issues-in-PPS-September-20111.pdf>

National Association of Medicaid Directors (NAMD) and Bailit Health. 2016. *The role of state Medicaid programs in improving the value of the health care system*. http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD_Bailit-Health_Value-Based-Purchasing-in-Medicaid.pdf



National Academy for State Health Policy (NASHP). 2016. *Value-based payment academy: Advancing value-based payment methodologies for federally qualified health centers and rural health clinics*. February 29, 2016.

<http://www.nashp.org/advancing-value-based-payment-methodologies-for-federally-qualified-health-centers-and-rural-health-clinics/>

Shin, P., J. Sharac, Z. Barber, and S. Rosenbaum. 2016. *Community health centers and Medicaid payment reform: Emerging lessons from Medicaid expansion states*. October 1, 2016.

<https://publichealth.gwu.edu/sites/default/files/downloads/GGRCHN/Community-Health-Centers-and-Medicaid-Payment-Reform-45.pdf>.

U.S. Government Accountability Office (GAO). 2005. *Health centers and rural clinics. State and federal implementation issues for Medicaid's new payment system*. Report no. GAO-05-452. Washington, DC: GAO.

<http://www.gao.gov/products/GAO-05-452>

Waldman, B. and Dyer, M.B. (2015). *Implementing state payment reform strategies at federally qualified health centers (FQHCs)*. Bailit Health Purchasing, LLC and James Waldinger, Public Consulting Group.

<http://statenetwork.org/resource/implementing-state-payment-reform-strategies-at-federally-qualified-health-centers-fqhcs/>

