

Emerging Issues in the FQHC Medicaid Prospective Payment System



Health centers provide high-quality, affordable primary and preventive health care, as well as services that facilitate access to care for millions of uninsured and medically underserved individuals nationwide, regardless of their ability to pay. Currently, nearly 1,400 health centers at over 11,000 sites serve more than 28 million patients nationwide.¹

In the Medicare and Medicaid programs, health centers are referred to as “federally qualified health centers” (FQHCs). Health centers play a vital role in Medicaid. In 2017, 49% of health patients had Medicaid as their primary source of insurance.²

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) established a Medicaid FQHC prospective payment system (PPS), effective for services rendered on or after January 1, 2001, to pay for a comprehensive range of services furnished by FQHCs.³ The Medicaid FQHC PPS, set forth in Section 1902(bb) of the Social Security Act (SSA), is a bundled, prospective cost-related payment methodology—a fixed, per-visit rate reflecting 100% of the center’s reasonable costs of furnishing covered services during a base period (Fiscal Years (FY) 1999 and 2000).

Each FQHC has a unique PPS rate based on its allowable costs. The rate is trended forward annually by an inflation index (typically the Medicare Economic Index, or MEI). The rate must also be adjusted as needed to reflect changes in the scope of service furnished by the center.

In the managed care context, states are required to make supplemental (or “wraparound”) payments to FQHCs to cover the difference between amounts paid to the FQHC by a Medicaid managed care entity and the FQHC’s PPS rate (if higher).

Under federal law, states may choose to use an alternative payment methodology (APM) instead of the FQHC PPS. However, a state’s payments to FQHCs under an APM must be at least equal to what an FQHC would have received under the PPS, and in addition, states may enforce an APM only if the affected FQHC agrees to it.

Today, new trends in state and federal policy implementation of the Medicaid FQHC PPS are affecting health centers’ experience as Medicaid providers. These trends represent opportunities, in that health centers

are able to play a key role in delivery system reforms and in expanding Medicaid managed care systems. They may also, in some instances, pose challenges, in that cost-related payment under Medicaid is essential in order for health centers to continue serving as safety-net providers of a comprehensive range of services to low-income and uninsured individuals.

This issue brief profiles four current policy trends involving the Medicaid FQHC PPS.

Rate Adjustments to Address Changes in the Scope of Services

For FY2002 and fiscal years thereafter, state Medicaid agencies are required to pay FQHCs at a rate equal to the previous year’s PPS rate, adjusted by an inflationary index—the MEI applicable to primary care services. States are also required under the statute to adjust an FQHC’s PPS rate to take into account “any increase or decrease in the scope of . . . services” furnished by the FQHC during the preceding fiscal year.⁴ For purposes of this rate adjustment, the Centers for Medicare & Medicaid Services (CMS) defined a change in the scope of services, in a 2001 [guidance](#), as “a change in the type, intensity, duration and/or amount of services.”⁵

¹ National Association of Community Health Centers (NACHC), August 2018 America’s Health Centers Fact Sheet at http://www.nachc.org/wp-content/uploads/2018/08/AmericasHealthCenters_FINAL.pdf

² United States Department of Health and Human Services (HHS), Health Resources & Services Administration (HRSA), 2017 Health Center Data (Grantees), Table 4 (Selected Patient Characteristics), at <https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2017&state=>

³ Two categories of services are encompassed in the bundled, cost-related FQHC PPS rate. “FQHC services” are defined as the services of physicians, physician assistants, nurse practitioners, clinical psychologists, and clinical social workers, and may include the services of visiting nurses in the case of centers in areas with a shortage of home health agencies. The FQHC benefit also includes any other ambulatory services that are offered by a specific FQHC and are included in the Medicaid State plan. SSA §§ 1905(a)(2)(C), 1905(l)(2)(A).

⁴ Social Security Act (SSA) § 1902(bb)(3).

⁵ Memorandum from Richard Chambers, Acting Director, Family and Children’s Health Programs Group, Health Care Financing Administration (now CMS), to Associate Regional Administrators (Sept. 12, 2001), re: BIPA Section 702 PPS for FQHCs, p. 6, at <http://www.nachc.org/wp-content/uploads/2015/11/PPS-Q-As-2001.pdf>.

The rate adjustment process for FQHCs is necessary for the Medicaid PPS methodology to work as it is designed—as a cost-related payment specific to scope of services furnished by each health center. It is an especially important tool during times when FQHCs are rapidly adopting new service delivery and practice management methods.

Each state has different policies concerning scope changes. For example, states define differently the specific events that constitute a change in the type, intensity, duration or amount of services. Similarly, states may have different methods for evaluating the cost impact of a scope change for purposes of the rate adjustment—although these methods typically involve the submission of a cost report by the FQHC. The state's scope change policy should ideally be detailed in the Medicaid State plan.

In recent years, some states have amended (or have applied to CMS to amend) their state plans to change or elaborate on their policies on FQHC PPS scope change. The revised provisions in some instances limit health centers' access to rate adjustments in inappropriate ways. For example, some states' policies do one or more of the following:

- Impose a minimum change in cost threshold (for example, an event must cause at least a 3% net increase in the FQHC's average cost per visit).
- Recognize scope changes associated only with the addition of new services, and not recognize (or not fully recognize) scope changes associated with increases in the intensity, duration, or amount of services.
- Refuse to recognize as a change in the scope of services expenditures for electronic health records or practice management systems, whose implementation has a direct impact on service delivery.
- Refuse to recognize the full cost impact associated with a change in the scope of services.
- Refuse to grant a rate adjustment unless an FQHC has notified the State of the rate adjustment request before implementing the change in the scope of services.

A related concern is that some states have never fully implemented a change in scope policy, or do not implement it continuously. In addition, some states that use an APM have not consistently processed PPS rate adjustment applications for FQHCs that are paid under the APM. Federal implementing guidance requires that

states annually compare their PPS rate to any rate under an APM, to ensure that FQHCs are being paid at least the rate required under the PPS. An accurate comparison is not possible if the State is not enforcing its documented scope change policies.

For more information on this topic, please see [NACHC Issue Brief #6: Defining an Effective Change in Scope Process](#).

Managed Care Supplemental Payments (“Wraparound”)

Under federal law, states are required to make payments to FQHCs to cover the difference between amounts paid to the FQHC by a Medicaid managed care organization (MCO) and the FQHC's PPS rate (if the latter is higher).⁶ These supplemental payments, which are made directly from the state to the FQHC, are sometimes referred to as “wraparound” payments. Additionally, states must require MCOs to pay FQHCs no less than the MCO would pay a provider that is not an FQHC for the same services.⁷

Today, Medicaid managed care is expanding rapidly nationwide, with 68% of Medicaid beneficiaries enrolled in comprehensive managed care in 2016, up from 51% in 2011.⁸ FQHCs are critical safety-net providers of a broad range of outpatient services in the Medicaid program. Consequently, policy issues concerning the intersection of managed care and the PPS system are prominent for FQHCs.

States pay Medicaid MCOs for the MCO's contracted scope of services through monthly payments that reflect the projected monthly costs of serving each enrollee, as certified by an actuary (sometimes called “capitation payments”). Generally, when states cover services through managed care, the capitation payment is the only payment the state makes for services furnished to MCO-enrolled individuals. States' FQHC wraparound payment obligation is one of the few exceptions to this principle.

⁶ SSA § 1902(bb)(5).

⁷ SSA § 1903(m)(2)(A)(ix).

⁸ HHS, CMS, Medicaid Managed Care Enrollment and Program Characteristics, 2016 (Spring 2018), Table 4 (p. 20), at <https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2016-medicaid-managed-care-enrollment-report.pdf>; HHS, CMS, Medicaid Managed Care: Trends and Snapshots, 2000-2013, Figure 2 (p. 8), at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2013-medicaid-managed-care-trends-and-snapshots-2000-2013.pdf>.

As states serve more and more Medicaid beneficiaries through managed care, some are seeking to avoid FQHC wraparound payments as a separate payment obligation, and instead, to delegate to the MCO the responsibility to pay FQHCs their full PPS rates. Under this scenario, in its contracts with MCOs, a state would consider the MCO's FQHC PPS payment obligation in developing capitation payments.

In April 2016, CMS issued [guidance](#) on this topic, advising that states may require MCOs to pay contracted FQHCs the full PPS rate for covered services, provided that they meet various requirements.⁹ Because the Medicaid statute requires direct supplemental payments from the state to the FQHC, states may delegate PPS payment to MCOs only through a CMS-approved APM documented in the Medicaid State plan. CMS made clear that states “would remain responsible for ensuring that FQHCs and Rural Health Clinics (RHCs) receive at least the full PPS reimbursement rate. States must continue their reconciliation and oversight processes to ensure that the managed care payments comply with the statutory requirements of the APM.”

If states delegate the PPS payment obligation to MCOs, and the MCOs in turn either do not follow the payment requirement or in other respects create barriers to FQHCs serving MCO enrollees (for example, through over-use of utilization controls or exclusion of the FQHCs from MCO networks), then health centers' central role in Medicaid is jeopardized. It remains to be seen whether the CMS guidance provides sufficient parameters to ensure that FQHCs can serve patients effectively in states that have chosen to delegate the PPS payment responsibility to MCOs.

Even in states that continue to pay wraparound to FQHCs, FQHCs and primary care associations (PCAs) continue to identify numerous obstacles in state policy or practice that can prevent FQHCs from receiving correct supplemental payment amounts. For example, some states:

- Do not make wraparound payments at least once per four months, as required by law.
- Do not timely reconcile wraparound payments made on a provisional basis.
- Improperly offset from the wraparound obligation amounts that should not be offset, such as payments for “extra” services that are not part of the FQHC benefit, or bonus payments.

- Deny wraparound if for any reason the MCO denied payment, even if the service furnished was a valid FQHC service (this is sometimes referred to as a “paid claim” policy).

FQHCs and PCAs should monitor states' adherence to the supplemental payment rules. Where PPS payment is delegated to MCOs, careful monitoring is needed to ensure that the arrangement does not limit FQHCs in serving Medicaid beneficiaries.

FQHC APMs Further Enable Health Centers to Participate in Delivery System and Payment Reforms

Under federal law, states may choose to use an APM instead of the PPS methodology, so long as the state complies with two statutory requirements.¹⁰ First, a state's payments to FQHCs under an APM must be at least equal to what the FQHC would have received under the PPS methodology. In addition, states may enforce an APM with respect to an FQHC only if that FQHC agrees to it. Any APM must be set forth in the Medicaid State plan.

The requirement that an APM result in payment at least equal to the PPS is not a hollow one. As CMS clarified in September 2001 [guidance](#), states are required to compute annually a PPS amount for each FQHC, even if the FQHC has elected to be paid under an APM.¹¹ States using an APM must annually compare payment under the APM for each FQHC for the prior year to payment under the PPS. As of 2017, more than 20 states had elected to use APMs.¹²

⁹ State Health Official Letter # 16-006, from Vikki Wachino, Director, Center for Medicaid & CHIP Services, CMS (Apr. 26, 2016), re: FQHC and RHC Supplemental Payment Requirements, pp. 2-3, at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd16006.pdf>.

¹⁰ SSA § 1902(bb)(6).

¹¹ Memorandum from Richard Chambers, Acting Director, Family and Children's Health Programs Group, Health Care Financing Administration (now CMS), to Associate Regional Administrators (Sept. 12, 2001), re: BIPA Section 702 PPS for FQHCs, pp. 7-8, at <http://www.nachc.org/wp-content/uploads/2015/11/PPS-Q-As-2001.pdf>.

¹² NACHC, The FQHC Alternative Payment Methodology Toolkit: Fundamentals of Developing a Capitated FQHC APM (July 2017), p. 6, at http://www.nachc.org/wp-content/uploads/2017/08/NACHC_APMTToolkit-1.pdf.

Broadly speaking, there are five common types of APMs.

- 1 Full FQHC PPS via Managed Care:** As previously discussed, some states are using APMs specifically in the managed care context, to obtain CMS approval to require MCOs to pay the full PPS rate.
- 2 Rebased Per-Visit Bundled Payment:** Some states have used APMs to “rebase” the FQHC per-visit rate— i.e., update the rate so that it is based on a more recent year’s average costs per visit. Because federal law requires the PPS rate to be based on FY1999-FY2000 costs, this type of update is considered an alternative methodology. Rebased the rate through an APM can help ensure that the per-visit rate bears a reasonable relation to health center costs. Because the MEI is an austere inflationary measure and because many states have not maintained effective scope change rate adjustment policies for FQHCs, annual increases in the PPS rates in some states have not kept pace with FQHCs’ cost experience.
- 3 Reasonable Cost Per-Visit Bundled Payment:** The third commonly used type of APM represents a continuation of the retrospective cost-based payment methodology that was used in Medicaid before the PPS was implemented in 2001. Some states (five, as of 2015) use an APM to carry out retrospective cost-based payment in lieu of the PPS.¹³ Under this methodology, FQHCs prepare an annual Medicaid cost report. FQHCs receive an interim per-visit payment based on average costs per visit in a prior year, and payments for each year are subject to reconciliation following the settlement of the cost report.
- 4 Per Member Per Month Bundled Payment:** Under a fourth common type of APM, gaining in popularity in recent years, states are seeking CMS permission to delink payment from the face-to-face visit, converting the existing FQHC PPS/APM to a capitated per member per month (PMPM) payment. Oregon¹⁴ and Washington¹⁵ have implemented such models, meaning that participating FQHCs in those states receive fixed monthly payments for attributed patients based on historical patient utilization. Health centers receiving payment under this methodology report that it allows for a more transformative use of the medical home, enabling them to maximize use of the care team and further meet the needs of their patients.
- 5 Bundled Payment with Quality Indicators:** While the majority are still under development, the fifth common type of FQHC APM provides incentives for meeting identified quality indicators while still ensuring total payments are not less than what health centers would have received under their FQHC PPS. APMs in Colorado¹⁶ and Washington¹⁷ represent two such models in which a portion of the payment is conditioned on the FQ HC’s performance on quality indicators. Washington’s model is a capitated methodology that incorporates quality indicators, while Colorado’s is a per-visit rate. Further work is needed to determine how best to incentivize addressing social risk as well as how to reward it.

¹³ NACHC, State Policy Report #57, 2015 Update on the Implementation of the FQHC Prospective Payment System (PPS) in the States (Dec. 2015), p. 3, at <http://www.nachc.org/wp-content/uploads/2015/10/2015-pps-report-2-6-161.pdf>.

¹⁴ NACHC, Spotlight on Health Center Payment Reform: Oregon Alternative Payment and Advanced Care Model (December 2016), at <http://www.nachc.org/wp-content/uploads/2017/08/Oregon-FQHC-APM-December-2017.pdf>

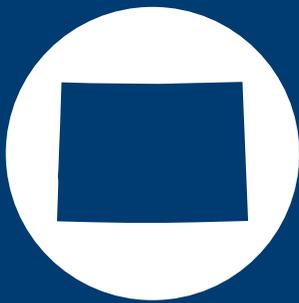
¹⁵ NACHC, Spotlight on Health Center Payment Reform: Washington State’s FQHC Alternative Payment Methodology (May 2018), at <http://www.nachc.org/wp-content/uploads/2018/05/NACHC-WA-APM-Case-Study-2018.pdf>.

¹⁶ Colorado Medicaid State Plan, Att. 4-19B, pp. I-A – I-I (TN No. 18-004, effective July 1, 2018), at <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CO/CO-18-0014.pdf>.

¹⁷ NACHC, Spotlight on Health Center Payment Reform: Washington State’s FQHC Alternative Payment Methodology (May 2018), at <http://www.nachc.org/wp-content/uploads/2018/05/NACHC-WA-APM-Case-Study-2018.pdf>.



OREGON became the first State to implement a FQHC APM using a capitated payment in March 2013. The FQHCs that have agreed to be paid under the APM receive a capitated per-member-per-month payment based on each FQHC's historical PPS payments and historic patient utilization data.¹⁸ The capitation payments are updated annually by the MEI. On a quarterly basis, the State reconciles the capitated payments with actual utilization data to determine whether the payments are at least equal to payment under the PPS. The capitated APM relates only to medical services; mental health, dental, and obstetrical services are paid for separately under PPS rates.



COLORADO implemented a FQHC APM using value-based payment, effective July 1, 2018.¹⁹ Under the APM, all FQHCs complete annual cost reports. For the first two years, FQHC payment rates will be 100% of reasonable cost, with separate Beginning in FY2020, a portion (up to 4 percent) of the APM payment is conditioned on the FQHC's performance on quality indicators in the prior year. FQHCs can select the quality indicators that will be used.

Importantly, under any APM, the state must maintain up-to-date PPS rates—including continuing to process rate change applications relating to changes in the scope of services. Moreover, under any APM, states are required to perform a reconciliation to ensure that FQHCs receive at least what they would receive under the PPS per-visit methodology. The reconciliation is typically conducted by comparing total FQHC payments in a time period under the APM to PPS payments (PPS rate multiplied by billable visits). Where, as under the Oregon model, FQHCs are paid on a purely capitated basis, it is important for the integrity of the reconciliation that FQHCs track billable visits through their practice management or electronic health record systems and report them to the State.

The financial risk that health centers assume under the payment reform APMs described above is limited by the assurance in the law of payment at least equal to the

PPS. It remains to be seen whether these value-based and performance-based methodologies will generate enough benefits, in terms of quality of care and patient outcomes, to warrant the costs of administration.

For more information on FQHC APMs using a capitated payment approach, see The FQHC Alternative Payment Methodology Toolkit (Fundamentals of Developing a Capitated FQHC APM).

¹⁸ NACHC, Spotlight on Health Center Payment Reform: Oregon Alternative Payment and Advanced Care Model (December 2016), at <http://www.nachc.org/wp-content/uploads/2017/08/Oregon-FQHC-APM-December-2017.pdf>

¹⁹ Colorado Medicaid State Plan, Att. 4-19B, pp. I-A – I-I (TN No. 18-004, effective July 1, 2018), at <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CO/CO-18-0014.pdf>.

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