



**ISSUE BRIEF**  
*Medicare/Medicaid Technical Assistance #69*

***Understanding the Medicaid Prospective Payment System for  
Federally Qualified Health Centers (FQHCs)***

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## ***I. Introduction***

On December 21, 2000, President Clinton signed the *Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA)*, included in the *Consolidated Appropriations Act of 2000*<sup>1</sup>, into law. This legislation included a provision establishing a minimum Medicaid per visit rate for Federally qualified health centers (FQHCs) using a prospective payment methodology (PPS). This provision repeals the phase-out and elimination of the reasonable cost payment system and provides a long-term replacement for the phase-out as enacted under the *Balanced Budget Act of 1997 (BBA)*.<sup>2</sup> Initial guidelines for the implementation of this policy were included in the attached January 19, 2001 letter from the Health Care Financing Administration (HCFA) to State Medicaid Directors.

Under the BBA and subsequent amendments enacted in 1999, States were not required by Federal law to provide a minimum Medicaid reimbursement to FQHCs after FY2004<sup>3</sup>. If the PPS had not been enacted and States had taken this option and reduced reimbursements to centers, it would have forced health centers to subsidize Medicaid losses from other sources, including the Section 330 Public Health Service (PHS) Act grants they receive to provide care for the uninsured.

The PPS reestablishes the Federal requirement that FQHCs be reimbursed at a minimum rate for services provided to Medicaid patients. This payment baseline is not nationwide but rather is based on the average of each FQHC's FY1999 and FY2000 reasonable costs per visit rates – therefore, it is a unique payment rate for each FQHC. For existing FQHCs, a baseline per visit rate is established for services provided between January 1, 2001 and September 30, 2001, and adjusted to take into account any change in the scope of services during that year. For FY2002 and years thereafter, the per visit rate equals the previous year's per visit rate, adjusted by the Medicare Economic Index (MEI) for primary care and any change in the FQHC's scope of services.

While the PPS establishes a Medicaid per visit payment rate floor, it does not require States to reimburse FQHCs using the PPS methodology. States may select an alternative payment methodology, including continuation of reasonable cost reimbursement, as long as that methodology (1) reimburses FQHCs at least what they would receive under the PPS and (2) is agreed to by the FQHC.

This issue brief will provide some contextual analysis regarding the passage of the PPS and explain the specific provisions of this new policy and how it is to be implemented.

## ***II. Legislative History of the Medicaid Prospective Payment System Methodology***

For more than thirty years, Congress has recognized the importance of the health center safety net for people living in America's medically underserved areas and those who have difficulty accessing affordable health care services. For more than a decade, Congress has also

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<sup>1</sup> P.L. 106-554

<sup>2</sup> Section 4712 of the Balanced Budget Act (P.L. 105-33)

<sup>3</sup> Section 603 of the Balanced Budget Refinements Act of 1999 (P.L. 106-113)

understood the relationship between adequate Medicaid reimbursements and a FQHC's ability to maximize the care it provides to the uninsured through PHS Act grants. Because Medicaid is frequently a FQHC's largest third party payer source, inadequate Medicaid payments have a direct impact on the appropriate use of Federal grant dollars to support care for the uninsured.

#### The Enactment of Medicaid Reasonable Cost Reimbursement

In 1989 and 1990, Congress passed legislation requiring FQHCs to be reimbursed on a reasonable cost basis for services provided to beneficiaries of the Medicare and Medicaid programs. Congress determined that inadequate Medicare and Medicaid reimbursements forced many FQHCs, as not-for-profit providers of health care for millions of uninsured Americans, to utilize Federal grant dollars received under Sections 329, 330, 340, and 340A of the Public Health Service Act<sup>4</sup> to subsidize low Medicaid payments. In turn, many FQHCs were forced to reduce care for uninsured patients, thereby undermining the Congressional mandate on centers to provide access to care.

Reasonable cost payments were intended to protect the PHS Act grant dollars by ensuring that FQHCs received adequate reimbursements from Medicare and Medicaid. Since the reasonable cost reimbursement system was enacted, FQHCs have doubled the number of uninsured patients for whom they provide care, despite the fact that expenditures for PHSA grants for health centers did not double during that time.

#### The *Balanced Budget Act of 1997* (BBA): Phase-out and Elimination of Reasonable Cost Reimbursement

In 1997, Congress passed and President Clinton signed the *Balanced Budget Act of 1997* into law. To arrive at a balanced federal budget in seven years, the BBA modified those Titles of the Social Security Act related to Medicare and Medicaid in an effort to meet budget targets established by the House of Representatives' and Senate's Budget Committees.

Because Congress had difficulty finding sufficient savings in the Medicaid program to meet the Budget Committees' targets, the House Commerce Committee turned to the reasonable cost reimbursement system for FQHCs and rural health clinics (RHCs) for savings. Even though the savings produced from eliminating the reasonable cost system were small relative to total Medicaid program spending, the National Governors' Association (NGA) sought to eliminate the reasonable cost reimbursement system immediately, arguing that the reasonable cost mandate limited State flexibility in developing a Medicaid program appropriate to the health care needs of the State. However, Congress did not eliminate the payment system immediately, believing that the phase-out compromise would allow FQHCs to adjust to a financial world without reasonable cost Medicaid reimbursement. This disregarded the reality that FQHCs would be forced to reduce care for the uninsured if Medicaid did not cover the FQHC's cost of providing services to its Medicaid beneficiaries.

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<sup>4</sup> In 1996, Sections 329, 330, 340 and 340A of the Public Health Service Act were consolidated into a single authority for the health centers program under Section 330 of the Public Health Service Act by the Health Centers Consolidation Act of 1996

Ultimately, the BBA gave States the option to phase-out the reasonable cost payment system over 5 years, eventually eliminating the Federal requirement after FY2003. The phase-out rates included in the BBA were as follows: FQHCs could receive no less than 95% of their reasonable costs in FY2000, 90% in FY2001, 85% in FY2002, 70% in FY2003. The reasonable cost payment system was to be repealed in its entirety in FY2003. The BBA also established a “wrap-around” payment mechanism, whereby States would reimburse FQHCs for the difference between the statutory payment rate and the amount they received under their contracts with Medicaid managed care organizations.

In 1999, Congress recognized that the policies enacted by the BBA went too far in reducing Medicare and Medicaid reimbursements to providers. At that time, only four States had enacted long-term legislation to ensure that FQHCs would receive 100% of their reasonable Medicaid costs. FQHCs in many other States had arrived at short-term agreements to continue Medicaid reasonable cost payments as well. In 1999, Congress enacted the *Balanced Budget Refinements Act* (BBRA). This legislation modified the BBA’s phase-out rates and delayed the elimination of the Medicaid reasonable cost reimbursement system for one year. However, the BBRA failed to enact a long-term solution to the elimination of reasonable cost reimbursement.

#### The Safety Net Preservation Act and the Passage of a Minimum Medicaid Per Visit Payment Rate Using a Prospective Payment Methodology

In an effort to secure an adequate long-term Medicaid payment system for FQHCs, NACHC and other health center advocates endorsed H.R.2341/S.1277, the *Safety Net Preservation Act*. This legislation established a Medicaid per-visit payment “floor” to guarantee FQHCs a minimum payment for services provided to Medicaid beneficiaries. This payment floor was calculated using a prospective payment methodology, whereby each FQHC would receive an initial year per visit rate (based on the FQHCs’ reasonable cost per visit) that would be adjusted annually for inflation and an increase in its scope of service.

The *Safety Net Preservation Act* was introduced by Representatives Richard Burr (NC) and Edolphus Towns (NY) in the House and Senators Charles Grassley (IA) and Max Baucus (MT) in the Senate. It was sponsored by 264 members of the House of Representatives and 59 members of the United States Senate. It was endorsed by more than 50 organizations representing elected officials, public health providers, and patient advocates. The legislation also received the qualified support of the Clinton Administration, which advocated for several changes in the legislative language as introduced. Because of its widespread support, the new Medicaid prospective payment methodology for Federally qualified health centers and rural health clinics was included in BIPA and signed into law on December 21, 2001.

Section III of this issue brief will provide greater detail about the PPS. It will examine the implications of HCFA’s policy and the steps that FQHCs and PCAs may wish to take to ensure that the new system is properly implemented in their State.

### **III. Explanation of HCFA's Letter to State Medicaid Directors (LSMD) Regarding Implementation of the Medicaid Prospective Payment Methodology for FQHCs**

The guidance in HCFA's January 19, 2001 LSMD is relatively limited in its specifics regarding the implementation of the PPS. Therefore, unless further guidance is released by HCFA, FQHCs and their State Primary Care Associations (PCAs) will have to work closely with their State Medicaid Offices and/or State Legislators to ensure that any outstanding issues are addressed in a manner that is consistent with the provisions of BIPA and HCFA's guidance.

#### **The PPS Applies to FQHCs in All States, Including Section 1115 Waiver States**

The LSMD is very clear that the requirements under Section 702 of BIPA establishing the FQHC PPS system are applicable to FQHCs in all States, including FQHCs in Section 1115 waiver States. The LSMD states...

*The new Medicaid PPS requirements are effective in all States with respect to services furnished by FQHCs/RHCs on or after January 1, 2001. Therefore, States must submit conforming State plan amendments before the end of the first calendar quarter...*

*A number of States currently have Section 1115 waivers of the FQHC/RHC cost-based reimbursement provisions under section 1902(a)(13)(C) of the Social Security Act as it existed prior to the enactment of Medicaid PPS. As discussed above, the BIPA repealed these provisions and established a new PPS in sections 1902(a)(15) and 1902(aa) of the Act. Thus, the waivers of section 1902(a)(13)(C) are no longer extant. All States, including those operating section 1115 waiver demonstration programs, are subject to the new Medicaid PPS requirements in sections 1902(a)(15) and 1902(aa) of the Act.*

This is a major victory for FQHCs in all States, particularly those in section 1115 waiver States. In some cases, FQHCs in 1115 waiver States have been suffering from extremely low Medicaid reimbursements since 1993. In many ways, the experience of FQHCs in these States has provided added urgency to the effort to reestablish a fair Federal Medicaid reimbursement requirement because of the devastating impact that the waiver of reasonable cost reimbursement has had on centers in those States.

However, all FQHCs and PCAs must be aware that a State may still seek a new waiver of this FQHC payment requirement under section 1115 of the Social Security Act. Therefore,

1. It is important that FQHCs work with their PCAs to ensure that there is a clear understanding of the State's position on implementation of the PPS;
2. FQHCs and PCAs must be mindful of the requirement that each State must submit to HCFA an amendment to their State Medicaid plan by March 31, 2001 to implement the PPS or an alternative payment system and ensure that such an amendment is consistent with Federal statute and any agreements made between the State and FQHCs; and

3. FQHCs, in conjunction with PCAs and NACHC should develop a careful advocacy strategy to combat any application for a waiver of the new payment requirements.

**CAUTION: In the event that a State moves to waive these reimbursement requirements or decides to ignore HCFA's statement that the PPS supercedes a FQHC 1115 waiver of prior cost based reimbursement provisions, it is important that FQHCs and PCAs rely on the improved advocacy capacity in their States and at NACHC to protect them from the potentially harmful actions of a State. FQHCs and PCAs should communicate in writing to HCFA and their State Medicaid Agency explaining why such a waiver is inconsistent with the objectives of the Medicaid statute. NACHC can assist you in this effort.**

### **Alternative Payment Methodologies**

To protect FQHCs that had already secured commitments to continue reasonable cost payments or other payment methodologies from their States, the PPS provides States with the option to develop and use an alternative Medicaid payment methodology to reimburse FQHCs using a non-PPS mechanism, if the State and a FQHC so choose, under certain requirements. In passing BIPA, Congress wanted to ensure that FQHCs that received Federal Section 330 grant dollars were not forced to divert those grants to cover low Medicaid reimbursements. The PPS establishes a payment floor to guard against such circumstances.

To that end, the LSMD (elaborating on BIPA) specifies the conditions under which a State may reimburse FQHCs using a mechanism other than the PPS...

*For the period beginning January 1, 2001 and ending September 30, 2001, and for any fiscal year beginning with FY2002, a State may, in reimbursing an FQHC or an RHC for services furnished to Medicaid beneficiaries, use a methodology other than the Medicaid PPS, but only if the following statutory requirements are met. First, the alternative payment methodology must be agreed to by the State and by each individual FQHC or RHC to which the State wishes to apply the methodology. Second, the methodology must result in a payment to the center or clinic that is at least equal to the amount to which it is entitled under the Medicaid PPS. Third, the methodology must be described in the approved State plan.*

To reiterate, any alternative Medicaid payment methodology for FQHCs must meet the following requirements...

1. *The alternative payment methodology must be mutually agreed to by the State and each individual FQHC.* Because each FQHC is empowered to determine whether the proposed alternative payment methodology is best for the center, the FQHC, not the State, has the authority to decide whether to accept or reject any alternative payment mechanism proposed by the State. FQHCs should examine the costs and benefits of any alternative payment mechanism relative to the PPS and make their decision based on such an examination.

2. *The alternative payment methodology must reimburse a FQHC in an amount that is not less than the amount the FQHC is entitled to under the Medicaid PPS. This requirement has two implications.*
  - a. First, the State must (and a FQHC should) calculate the Medicaid PPS payment rates for a FQHC before proposing (or accepting) an alternative Medicaid payment methodology. This is necessary to ensure that the alternative mechanism is consistent with Federal statute and HCFA's guidance.
  - b. Second, a FQHC and a State may not agree to an alternative payment methodology if it reimburses less than the PPS-calculated amount. Such a payment methodology is in violation of Federal law.
3. *The alternative payment methodology must be described in the approved State plan, which a State must file with HCFA no later than March 31, 2001. In order for an alternative payment methodology to meet Federal requirements, a State must file the alternative methodology to HCFA as an amendment to its Medicaid State plan. ***This requirement applies to any legislative or administrative agreement to continue a cost-based reimbursement system.*** If there are different payment methodologies for different FQHCs in one State, each payment methodology must be described in the State's Medicaid plan and that plan must be approved by HCFA.*

In summary, States, PCAs, and FQHCs should understand that (1) the new PPS applies to FQHCs in all 50 States, the District of Columbia, Puerto Rico, and the U.S. Territories and (2) a State may reimburse FQHCs under an alternative methodology, including cost-based reimbursement, as long as the conditions outlined above are met. It is important that all FQHCs and PCAs understand the previous two provisions before moving on to the calculation of the per visit payment rates under the PPS.

**CAUTION: It is important that FQHCs carefully consider the pros and cons of agreeing to an alternative payment methodology. For example, if a State's alternative methodology is 100% reasonable cost plus caps and screens, PPS may be a better methodology in the long run (since it may not include the calculation of caps or screens after the base year).**

### **New PPS Payment Provisions for Existing FQHCs**

The PPS included in BIPA was fundamentally intended to protect FQHCs from the elimination of the Federal reasonable cost reimbursement requirements under the BBA. Had the BBA gone fully into effect and States eliminated reasonable cost payments entirely, FQHCs would have lost millions of dollars in Medicaid revenues, forcing them to reduce care for their uninsured patients. BIPA establishes a methodology for calculating a minimum Medicaid per visit rate for FQHCs – in essence, it creates a “payment floor” for each FQHC.

It is easiest to consider the PPS methodology in two parts. The first part is the establishment of a baseline payment rate for each FQHC for Medicaid-covered services<sup>5</sup> provided between January 1, 2001 and September 31, 2001. The second part is payment for FQHC Medicaid-covered services provided in FY2002 and in fiscal years thereafter. The following examines each of those parts in greater detail.

### Establishing the PPS Baseline Payment

The LSMD outlines the requirements for establishing a baseline Medicaid payment rate for each FQHC for services provided between January 1, 2001 and September 30, 2001...

*In the first phase of the new Medicaid PPS (January 1, 2001 – September 30, 2001), States are required to pay current FQHCs/RHCs 100 percent of the average of their reasonable costs of providing Medicaid-covered services during FY1999 and FY2000, adjusted to take into account any increase (or decrease) in the scope of services furnished during FY2001 by the FQHC/RHC (calculating the payment amount on a per visit basis.)*

NACHC requested that HCFA provide clarifying guidance to address a number of issues concerning BIPA's PPS for FQHCs. Unfortunately, HCFA did not provide the amount of detail that NACHC had hoped for in its initial guidance. NACHC anticipates that additional guidance will be issued by HCFA. However, in the interim, it is important for FQHCs and PCAs to understand some of the outstanding issues identified by NACHC that FQHCs and PCAs should address with their State when developing their policy regarding implementation of the PPS.

1. Use of Final Reconciled Cost Reports: Clearly, given the time it takes for States and FQHCs to reconcile Medicaid cost reports, it will be nearly impossible for a State to quickly determine the PPS baseline. In many cases, it could take as long as a year (or longer) for a FQHC and the State to arrive at a final cost report. Therefore, we urge FQHCs and PCAs to (1) work with the State to develop an interim payment baseline that is reasonable and can be used until FY1999 and FY2000 cost reports are finalized, and (2) ensure that the State uses reconciled cost reports in its calculations of FY1999 and FY2000 costs.

**CAUTION: In calculating costs for FY2000, be sure the State calculates on the basis of 100% of reasonable costs, not 95% (as was allowed under the BBA).**

2. Weighted Averaging of FY1999 and FY2000 Rates: BIPA requires a State to establish a FQHC's reasonable costs per visit in FY2001 based on its average per visit

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<sup>5</sup> As described in Section 1905(a)(2)(C) of the Social Security Act, Medicaid-covered FQHC services include (1) physician services, (2) such services and supplies as are covered under Section 1861(s)(2)(A) of the Social Security Act (SSA) if furnished as an incident to a physician's professional services and items and services described in Section 1861(s)(10) of the SSA, (3) services provided by a physician assistant or (4) nurse practitioner, (5) a clinic psychologist, or (6) by a clinical social worker, (7) [for (3) – (6)] such services and supplies furnished as an incident to his service as would otherwise be covered if furnished by a physician or as an incident to a physician's service, (8) preventive primary health services that a center is required to provide under section 330 of the Public Health Service Act, and (9) any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the [State's Medicaid] plan.

cost in FY1999 and FY2000 when calculating the PPS baseline rate. However, because most FQHCs will likely have incurred increasing costs from FY1999 to FY2000, a flat averaging will not capture the true cost differences between those two years. NACHC encourages FQHCs and PCAs to urge the State to develop and use a weighted average that provides for a higher percentage of the average for the fiscal year with the higher costs, particularly if such a year was FY2000.

3. Application of Caps and Screens to FY1999 and FY2000 Rates – BIPA establishes a baseline payment rate to accurately reflect the costs of a FQHC in providing FQHC Medicaid-covered services. It is important to note that the legislative language of the BIPA provides that the baseline be calculated on a FQHC's costs, not payments or payment rates<sup>6</sup>, including payments or rates that are limited by "caps" or "screens." **CAUTION: NACHC urges all FQHCs to ensure that amounts calculated by the State under the PPS are consistent with Federal law that requires such payments to be based on the reasonable costs of providing services. Therefore, FQHCs and PCAs will need to be vigilant in ensuring that States do not employ payment screens (such as minimum productivity screens) or overall payment caps in calculating the baseline PPS rates for FQHCs, especially where such screens and caps were not used in setting the Medicaid FQHC payment rates for FY1999 and FY2000.**
4. Material Changes in a FQHC's Scope of Service – Neither BIPA or the LSMD defines how a State or FQHC should calculate "an increase (or decrease) in the scope of services..." A FQHC may periodically change its scope of service and such a change may have a material impact on that FQHC's costs per visit. It seems unreasonable that a State require a FQHC to recalculate its Medicaid per visit rate if a change in its scope of services makes only a negligible impact on its per visit rate. Therefore, NACHC urges all FQHCs and PCAs to work with their State Medicaid agency to establish a reasonable definition for change in the scope of services that (a) takes into account changes in the scope of Medicaid-covered services that a FQHC may have added or deleted, (b) uses cost reports on either a projected or actual basis (or combination) that will provide a rate for all Medicaid-covered services, and (c) takes into account a change in the intensity of Medicaid services which would significantly increase or decrease (for example, by +/- 5%) in the PPS per visit rate (i.e. adding high cost services like pharmacy or radiology).

**Ensuring a proper calculation of the PPS baseline is essential to provide a strong and accurate foundation for all future payments to a FQHC in the Medicaid program.** Therefore, FQHCs and PCAs should work to ensure that the methodology that a State uses to

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<sup>6</sup> New Section 1902(aa)(2) states "...for services furnished on and after January 1, 2001, during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used under section 1833(a)(3) adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001."

calculate the PPS baseline accurately represents those costs associated with providing covered services to the FQHC's Medicaid patients.

Payments for Services in FY2002 and Years Thereafter

The baseline is the foundation for accurately calculating minimum payments under the PPS and ensuring that any alternative payment methodologies meet the Congressional intent that grant dollars not be used to subsidize low Medicaid payments. Once the baseline is established, the PPS per visit rate is adjusted in subsequent years by (1) the Medicare Economic Index (MEI)<sup>7</sup> for primary care (a measure of inflation) and (2) any change in the scope of services furnished by a FQHC during that fiscal year. Again, this is only a minimum Medicaid per visit rate – an alternative payment methodology that is agreed to by the FQHC and reimburses a FQHC at the same or higher rate would be acceptable under Federal law.

Payments for FQHC services provided in fiscal year 2002, and for all fiscal years thereafter, are as follows:

*Beginning in FY2002, and for each fiscal year thereafter, each FQHC/RHC is entitled to the payment amount (on a per visit basis) to which the center or clinic was entitled under*

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<sup>7</sup> The following excerpt from HCFA's Internet document entitled "Background Information on Data Sources and Methods" describes in greater detail the Medicare Economic Index.

*In 1972, Congress mandated the development of the Medicare Economic Index (MEI) to measure the changes in costs of physicians' time and operating expenses. The input price change measured by the MEI is considered in connection with the update factor for the Medicare Part B physician fee schedule under the Resource-Based Relative Value Scale (RBRVS, November 22, 1996 Federal Register), or is used as an advisory indicator by Congress in updating the fee schedule. The MEI is a fixed-weighted sum of annual price changes for various inputs needed to produce physicians' services with an offset for productivity increases...*

*...the MEI is constructed in two steps. First, a base period is selected (1996 for the MEI), cost categories are identified, and the 1996 expenditure shares by cost category are determined. Second, price proxies are selected to match each relative expenditure category. These proxies are weighted by the category weight determined from expenditure amounts, and summed to produce the composite MEI...*

*...the compensation portion of the MEI is adjusted for productivity so both economy-wide productivity and physician practice productivity are not both included in the update, resulting in a double counting of productivity.*

*Forecasts of the MEI are made periodically throughout the fiscal year by Standard & Poor's/DRI for HCFA using several different sets of economic assumptions. Standard & Poor's/DRI produces 4 main forecasts of the MEI: a Presidential budget forecast in December and the Mid-session Review in June based on assumptions for the Federal budget exercises, the Medicare Trustees Report forecast in February based on assumptions by the Medicare Trustees, and the Medicare Premium Promulgation forecast in August based on baseline assumptions by Standard & Poor's DRI. Standard & Poor's DRI also produces forecasts of the MEI using their own economic assumptions forecast. The forecasts based on Standard & Poor's DRI assumptions are presented in Health Care Indicators. Much of the forecasted data changes as more recent historical data becomes available and the assumptions change.*

*the Act in the previous fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the FQHC/RHC during that fiscal year.*

For all FQHC Medicaid-covered services provided in FY2002 and fiscal years thereafter, the above formula is what a State must use to calculate per visit reimbursements to a FQHC or to determine if an alternative payment methodology is no less than the rate required to be paid to a FQHC.

**CAUTION: Once the FQHC's PPS rate is established, the State cannot apply caps and screens to that rate.**

### **PPS Payment Provisions for New FQHCs**

FQHCs that are certified or funded after September 30, 2000 will have a much more difficult time when calculating the Medicaid PPS rate than FQHCs that had been operating before that time. Because the PPS baseline is calculated using a FQHC's FY1999 and FY2000 reasonable costs, it is impossible to calculate a baseline for a FQHC using cost data from those years if they had not been operational at the time. However, envisioning the expansion of FQHCs, BIPA and HCFA's LSMD provides a mechanism to calculate baseline payments for FQHCs that were certified or funded after FY2000.

The LSMD states,

*Newly qualified FQHCs/RHCs after fiscal year 2000 will have initial payments established either by reference to payments to other clinics in the same or adjacent areas, or in the absence of such other clinics, through cost reporting methods. After the initial year, payment shall be set using the MEI methods used for other clinics.*

The legislative language regarding the establishment of initial year payment amounts for new FQHCs is somewhat more specific than that outlined in the LSMD. The law reads,

*In any case in which an entity first qualifies as a Federally-qualified health center or rural health clinic after fiscal year 2000, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by the center or services described in section 1905(a)(2)(B) furnished by the clinic in the first fiscal year in which the center or clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during such fiscal year based on the rates established under this subsection for the fiscal year for other such centers or clinics located in the same or adjacent area with a similar case load or, in the absence of such a center or clinic, in accordance with the regulations and methodology referred to in paragraph (2) or based on such other tests of reasonableness as the Secretary may specify. For each fiscal year following the fiscal year in which the entity first qualifies as a Federally-qualified health center or rural health clinic, the State plan shall provide for the payment amount to be calculated in accordance with paragraph (3).*

While this mechanism seems to be fairly straightforward, it does suffer from a lack of specificity. Absent further guidance from HCFA, PCAs will have to work with new FQHCs and negotiate with their State's Medicaid Office to ensure that the law is applied in a manner most favorable to the FQHC.

1. "Same or adjacent area": Because of the nature of FQHCs and their uniqueness as community providers, it may be difficult to identify a FQHC that is in the same or adjacent area. If the closest FQHC to a newly qualified rural FQHC is an urban FQHC with a large homeless population, can the State assume that the urban FQHC's costs are a proxy for the costs of the rural FQHC? NACHC urges PCAs to work with their State to ensure that the definition of a FQHC in a "same or adjacent area" truly captures the costs for the new FQHC.
2. "Similar caseload": In addition to the payment rate for a new center being based on the costs for an adjacent center, BIPA also requires that adjacent center to have a similar caseload. However, neither BIPA nor the LSMD defines the term "similar caseload." Again, barring further guidance from HCFA, NACHC urges PCAs to consult with FQHCs and negotiate with their State's Medicaid Office to ensure that the State's methodology for calculating PPS payment rates for new FQHCs meets the statutory requirements of BIPA in a manner that truly captures the costs for the new FQHC.
3. Using an Entity's Cost History: Not all new FQHCs will be new entities. Some new FQHCs may be provider entities that have a cost history because they were operational before receiving FQHC status. Therefore, NACHC urges PCAs to work with States to ensure that, when negotiating the terms and conditions of the PPS payment methodology for new FQHCs that consideration be given to an entity's cost history if it was operational before receiving FQHC status.

### **Continuation of Supplemental Payments to Managed Care Subcontractors<sup>8</sup>**

The BBA first established the requirement that States reimburse FQHCs that contract with managed care organizations (MCOs)<sup>9</sup> the difference between their cost-based payment rates and the amount of reimbursement paid to FQHCs by MCOs. This so-called "wrap-around," or supplemental, payment was enacted to ensure that MCOs that contract with a State to provide services to Medicaid beneficiaries did not have a financial disincentive to contract with FQHCs. Under this requirement, a MCO is not required to reimburse a FQHC any more than it would reimburse a provider of similar services.

BIPA continues the BBA's supplemental payment requirements. HCFA's letter states,

*In many States, Medicaid Managed Care Entities (MCEs) subcontract with FQHCs/RHCs to furnish covered services to Medicaid enrollees. As was the case under the law*

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<sup>8</sup> FQHCs should also refer to the reimbursement requirements outlined in the Health Care Financing Administration's Letter to State Medicaid Directors on September 29, 2000 and NACHC Issue Brief #67 which provides further guidance on these requirements.

<sup>9</sup> As defined in Section 1903(m) of the Social Security Act.

*in effect prior to January 1, 2001, BIPA requires States to make supplemental payments to FQHCs/RHCs that subcontract (directly or indirectly) with MCEs representing the difference, if any, between the payment received by the FQHC/RHC for treating the MCE enrollee and the payment to which the FQHC/RHC would be entitled for visits under the Medicaid PPS provisions of BIPA. The State may determine if the Medicaid PPS reimbursement to which the FQHC/RHC is entitled exceeds the amount of payments received by the FQHC/RHC and, if so, it must pay the difference to the FQHC/RHC. The State plan should be amended to include a description of the supplemental payment methodology.*

The legislative language also provides an additional requirement...

*The supplemental payment required under subparagraph (A) shall be made pursuant to a payment schedule agreed to by the State and the Federally qualified health center or rural health clinic, but in no case less frequently than every 4 months.*

The changes in the supplemental payment provisions, while apparently small, actually represent significant changes in the “wrap-around” policy. First, the wrap-around payment requirements now include contracts that FQHCs have with “managed care entities” or MCEs<sup>10</sup>. An MCE is defined to include managed care organizations, as well as primary care case management contracts. Second, the LSMD also clarifies that FQHCs are entitled to wrap-around payments, regardless of whether they contract directly with the MCE or indirectly as subcontractors to the entity that contracts with the MCE, i.e. the FQHC is part of a provider network.

Therefore,

1. FQHCs have the right to receive supplemental payments for the difference between the amounts received under their contracts (either directly or indirectly) with MCEs and the amounts to which they are entitled under the PPS calculation; and
2. FQHCs have the right to negotiate a schedule for payment of these supplemental payments, but such a payments cannot be paid any less frequently than every four months.

Unlike the BBA, the BIPA allows a FQHC to negotiate with the State the schedule of supplemental payments. The BBA required that these payments be made quarterly.

**CAUTION:** HCFA’S LSMD of September 29, 2000 makes clear that, under the BBA, HMO bonus payments to FQHCs are not to be included as reimbursement to the FQHC when the State calculates “wrap-around” payments owed to a FQHC. This policy would appear to be appropriate and applicable under the PPS’ “wrap-around” requirements.

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<sup>10</sup> As defined in Section 1932(a)(1)(B) of the Social Security Act

#### **IV. Implications and Activities for FQHCs**

Clearly, the new Medicaid prospective payment methodology has great implications for FQHCs and the manner in which they provide care and receive reimbursements from State Medicaid programs. The following is a list of things that FQHCs should be aware of and the implications that the PPS may have on the operation of their center.

1. If a State implements the new Medicaid PPS, FQHCs will need to manage their budgets within a fixed rate, albeit one that is increased by the MEI and adjusted for changes in the scope of services provided by the FQHC. Under the PPS, a FQHC that controls its Medicaid costs and keeps its per visit payments below the minimum PPS payment rate can actually reap the difference in those two amounts. This is unlike cost-based reimbursement where a health center is not rewarded for reducing its costs by becoming more efficient.
2. Unlike cost-based reimbursement, there is no retrospective reconciliation under the PPS. This means that FQHCs will be forced to have (and use) increasingly sophisticated information around costs by patient and payer source. NACHC encourages health centers to develop analytic tools, such as RVU analysis, etc., in order to understand precisely the implications that changes in utilization and intensity have on their costs.
3. Establishing the PPS base rate is very important and will establish the foundation for all FQHC Medicaid payments in the future. FQHCs should spend adequate time ensuring that their cost reports used in setting their base (first year) PPS rate are accurate and comprehensive. NACHC urges all FQHCs to seek technical assistance as required to ensure that cost reports, and therefore the PPS baseline, accurately reflect the Medicaid costs of a center.
4. FQHCs should not act as “lone rangers.” While the Federal law allows health centers to approve of a State proposed alternative payment methodology other than the PPS, FQHCs stand to lose significantly if appropriate attention is not paid to the State’s implementation of the PPS. NACHC urges all FQHCs to work in concert with their PCA to ensure that the State Medicaid Agency elects options and methodologies that are most favorable to the FQHCs.

While this should not be considered a comprehensive list of implications, FQHCs should be aware of how they can benefit from the differences in the PPS and cost-based reimbursement methodologies, as well as understand the new challenges posed by those differences.

#### **V. Conclusion**

Under the Medicaid PPS, the law empowers FQHCs, working with their State Primary Care Associations, to negotiate with their State’s Governor, Legislature, and Medicaid Agency the best possible payment methodology for FQHCs in the State, with the understanding that Congress must maintain the integrity of the nationwide health center safety net by guaranteeing a minimum Medicaid per visit payment for FQHCs.

NACHC is in the process of developing training sessions for Primary Care Associations and FQHCs regarding the implementation of the PPS. The sessions will focus on strategies for working together with PCAs and State Medicaid Agencies and will provide technical information on legal, financial, and policy issues associated with the PPS. This training schedule will be sent to all health centers and PCAs. It is important that all centers attend these sessions to ensure that the promise of the PPS is realized in implementation. Also, be sure to check [www.nachc.com](http://www.nachc.com) for additional information about the PPS.

### **Attachments**

Appendix I – Checklist for PCAs and FQHCs Regarding the Implementation of the Medicaid Prospective Payment Methodology

Appendix II – **Legislative** Language of Section 702 of the *Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (H.R.5661)*

Appendix III – **Report Language** for Section 702 of the *Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (H.R.5661)*

Appendix IV – **HCFA's Letter to State Medicaid Directors** regarding implementation of the Medicaid PPS for FQHCs

**Appendix I**  
**Checklist for FQHCs and PCAs Regarding Implementation of the Medicaid  
Prospective Payment Methodology**

This attachment is a checklist that FQHCs and PCAs can use when evaluating the proposal made by a State regarding the implementation of the Medicaid PPS or an alternative Medicaid methodology. The issues in this checklist track those issues described in greater detail in Issue Brief #69.

**Consistency with Congressional Intent**

- Does the State's proposed methodology recognize Congressional intent to ensure that Medicaid payments to FQHCs are adequate to protect Federal Public Health Service grants intended to provide care for uninsured patients?

**State's Intent to Implement the New Medicaid PPS for FQHCs**

- What is the State's position on implementation of the PPS? Will the State implement a payment methodology that is consistent with Federal law or will it seek a waiver of this new requirement?
  - Does the State understand that HCFA's Letter to State Medicaid Directors requires States to submit a conforming amendment to its State Medicaid plan by no later than March 31, 2001?
- If the State's Medicaid program operates under a Section 1115 waiver of the repealed cost-based reimbursement system, does the State understand that the new Medicaid PPS applies to all FQHCs in that State?
- Does the State intend to continue paying all FQHCs under its current payment methodology (such as a cost-based payment system) on an interim basis, at least until it fully implements a new PPS system or an acceptable alternative?

**Implementation of Alternative Payment Methodologies**

- Will the State submit an amendment to the State's Medicaid plan to HCFA by March 31, 2001 that brings the State into compliance with Federal law mandating reimbursements to FQHCs?
  - Have FQHCs and PCAs received copies of the amended State Medicaid plan that would implement the PPS or alternative payment methodology?

- If the State is (or will be) proposing one or more different methodologies for Medicaid reimbursements to different FQHCs, does the State plan amendment outline each of those proposed methodologies?
- ☑ If the State is proposing an alternative payment methodology, does the alternative...
  - Provide Medicaid reimbursements to FQHCs that are at least what the FQHC would have received under the prospective payment methodology?, and
  - Meet with the approval of all FQHCs for which the State seeks to apply the new alternative payment methodology?
- ☑ Because of the importance to alternative payment methodologies in establishing an accurate baseline calculation under the PPS, have FQHCs, the PCA, and the State negotiated the underlying requirements of the PPS methodology so that it accurately represents the methodology described in Federal law and maximizes, to the extent possible, Medicaid reimbursements to FQHCs?

#### **Calculating the Prospective Payment Baseline Calculation**

- ☑ Will the State use the final, reconciled cost reports for each FQHC for FY1999 and FY2000?
  - Has the State agreed to continue its interim payment system until the time that the FY1999 and FY2000 cost reports are reconciled?
  - Is the State using a methodology that is consistent with Federal cost principles and that takes into account the total reasonable costs of providing services to Medicaid patients?
  - Does the methodology use cost reports (i.e. Medicare cost reports) that fail to include all Medicaid covered services?
  - Is the State applying caps and screens to the calculations of reasonable costs in calculating the PPS baseline?
    - If so, are these caps and screens consistent with Federal law?
    - Have these caps and screens been used before, or is the State employing newly-developed caps and screens for the purpose of depressing the baseline PPS rate calculation?
- ☑ Will the State use a flat average of FY1999 and FY2000 reasonable costs, or will it use a weighted average that takes into account higher costs in one year over another?
- ☑ When defining "change in the scope of service"...

- Does the definition take into account changes in the number or types of Medicaid-covered services that a FQHC may have added or deleted?
- Does the definition take into account a change in the intensity of Medicaid services (i.e. the increased use of OB/GYN services or EPSDT services by the Medicaid population)?
- Does the definition require that any changes in a FQHC's scope of services must meet a minimum threshold (e.g. +/- 5%) on the per visit rate before such changes trigger an adjustment in the FQHC's PPS rate?

### **Payment Calculations for New FQHCs**

- Have FQHCs and PCAs worked with the State to ensure that a payment methodology is developed for FQHCs that are created after September 30, 2001? Does this methodology meet the requirements outlined in Federal law and HCFA's guidance? Does the methodology ensure that new FQHCs are adequately reimbursed for services provided to Medicaid patients?
  - Has the State established a reasonable definition of "same or adjacent area"?
  - Has the State established a reasonable definition of "similar caseload"?

### **Supplemental, or "Wrap-Around", Payments**

- In implementing the supplemental or "wrap-around" payment requirements, under BIPA, does the State understand that BIPA requires "wrap-around" payments be made to FQHCs...
  - that contract with all types of Medicaid managed care entities (for example, a primary care case management system, or PCCM), not just with managed care plans (or MCOs)?
  - that contract wither directly or indirectly (i.e. through a network) with a managed care entity (MCE)?
- Has the State worked with the FQHC to develop a schedule for "wrap-around" payments that makes such payments no less than every four months?

### **NACHC Trainings**

- Will the PCA attend NACHC's PCA February briefings on the implementation of the PPS?

- Will a representative from your FQHC attend NACHC's briefings for FQHCs, beginning in March, on the implementation of the PPS?

**LEGISLATIVE LANGUAGE FOR A NEW MEDICAID PROSPECTIVE  
PAYMENT SYSTEM FOR FEDERALLY QUALIFIED HEALTH CENTERS**

**SEC. 702. NEW PROSPECTIVE PAYMENT SYSTEM FOR FEDERALLY-  
QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.**

(a) IN GENERAL- Section 1902(a) (42 U.S.C. 1396a(a)) is amended--

(1) in paragraph (13)--

(A) in subparagraph (A), by adding 'and' at the end;  
(B) in subparagraph (B), by striking 'and' at the end; and  
(C) by striking subparagraph (C); and

(2) by inserting after paragraph (14) the following new paragraph:

'(15) provide for payment for services described in clause (B) or (C) of section 1905(a)(2) under the plan in accordance with subsection (aa);'.

(b) NEW PROSPECTIVE PAYMENT SYSTEM- Section 1902 (42 U.S.C. 1396a) is amended by adding at the end the following:

'(aa) PAYMENT FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED  
HEALTH CENTERS AND RURAL HEALTH CLINICS-

'(1) IN GENERAL- Beginning with fiscal year 2001 with respect to services furnished on or after January 1, 2001, and each succeeding fiscal year, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by a Federally-qualified health center and services described in section 1905(a)(2)(B) furnished by a rural health clinic in accordance with the provisions of this subsection.

'(2) FISCAL YEAR 2001- Subject to paragraph (4), for services furnished on and after January 1, 2001, during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used under section 1833(a)(3), adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001.

`(3) FISCAL YEAR 2002 AND SUCCEEDING FISCAL YEARS- Subject to paragraph (4), for services furnished during fiscal year 2002 or a succeeding fiscal year, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for such services under this subsection for the preceding fiscal year--

`(A) increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) for that fiscal year; and

`(B) adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during that fiscal year:

`(4) ESTABLISHMENT OF INITIAL YEAR PAYMENT AMOUNT FOR NEW CENTERS OR CLINICS- In any case in which an entity first qualifies as a Federally-qualified health center or rural health clinic after fiscal year 2000, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by the center or services described in section 1905(a)(2)(B) furnished by the clinic in the first fiscal year in which the center or clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during such fiscal year based on the rates established under this subsection for the fiscal year for other such centers or clinics located in the same or adjacent area with a similar case load or, in the absence of such a center or clinic, in accordance with the regulations and methodology referred to in paragraph (2) or based on such other tests of reasonableness as the Secretary may specify. For each fiscal year following the fiscal year in which the entity first qualifies as a Federally-qualified health center or rural health clinic, the State plan shall provide for the payment amount to be calculated in accordance with paragraph (3).

`(5) ADMINISTRATION IN THE CASE OF MANAGED CARE-

`(A) IN GENERAL- In the case of services furnished by a Federally-qualified health center or rural health clinic pursuant to a contract between the center or clinic and a managed care entity (as defined in section 1932(a)(1)(B)), the State plan shall provide for payment to the center or clinic by the State of a supplemental payment equal to the amount (if any) by which the amount determined under paragraphs (2), (3), and (4) of this subsection exceeds the amount of the payments provided under the contract.

`(B) PAYMENT SCHEDULE- The supplemental payment required under subparagraph (A) shall be made pursuant to a payment schedule agreed to by the State and the Federally-qualified health center or rural health clinic, but in no case less frequently than every 4 months.

(6) ALTERNATIVE PAYMENT METHODOLOGIES- Notwithstanding any other provision of this section, the State plan may provide for payment in any fiscal year to a Federally-qualified health center for services described in section 1905(a)(2)(C) or to a rural health clinic for services described in section 1905(a)(2)(B) in an amount which is determined under an alternative payment methodology that--

(A) is agreed to by the State and the center or clinic; and

(B) results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under this section.'

(c) CONFORMING AMENDMENTS-

(1) Section 4712 of the BBA (Public Law 105-33; 111 Stat. 508) is amended by striking subsection (c).

(2) Section 1915(b) (42 U.S.C. 1396n(b)) is amended by striking '1902(a)(13)(C)' and inserting '1902(a)(15), 1902(aa).'

(d) GAO STUDY OF FUTURE REBASING- The Comptroller General of the United States shall provide for a study on the need for, and how to, rebase or refine costs for making payment under the medicaid program for services provided by Federally-qualified health centers and rural health clinics (as provided under the amendments made by this section). The Comptroller General shall provide for submittal of a report on such study to Congress by not later than 4 years after the date of the enactment of this Act.

(e) EFFECTIVE DATE- The amendments made by this section take effect on January 1, 2001, and shall apply to services furnished on or after such date.

**Report Language Accompanying the New Medicaid Prospective  
Payment System for Federally Qualified Health Centers**

*Section 702. New prospective payment system for Federally-qualified health centers and rural health clinics*

The provision would create a new Medicaid prospective payment system for federally qualified health centers (FQHCs) and rural health centers (RHCs) beginning in January of FY2001. Existing FQHCs and RHCs would be paid per visit payments equal to 100% of the average costs incurred during 1999 and 2000 adjusted to take into account any increase or decrease in the scope of services furnished. For entities first qualifying as FQHCs or RHCs after 2000, the year visit payments would begin in the first year that the center or clinic attains qualification and would be based on 100% of the costs incurred during that year based on the rates established for similar centers or clinics with similar caseloads in the same or adjacent geographic area. In the absence of such similar centers or clinics, the methodology would be based on that used for developing rates for established FQHCs or RHCs or such methodology or reasonable specifications as established by the Secretary. For each fiscal year thereafter, per visit payments for all FQHCs and RHCs would be equal to amounts for the preceding fiscal year increased by the percentage increase in the Medicare Economic Index applicable to primary care services for that fiscal year, and adjusted for any increase or decrease in the scope of Services furnished during the fiscal year. In managed care contracts, States must make supplemental payments to the center or clinic that would be equal to the difference between contracted amounts and the cost-based amounts. Those payments would be paid on a schedule mutually agreed to by the State and the FQHC or RHC. Alternative payment methods would be permitted only when payments are at least equal to amounts otherwise provided.

The provision would also direct the Comptroller General to provide for a study on how to rebase or refine cost payment methods for the services of FQHCs and RHCs. The report would be due to Congress no later than 4 years after the date of enactment.



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January 19, 2001

Dear State Medicaid Director:

This letter provides initial guidance on the new Medicaid prospective payment system for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) recently enacted into law under section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000.

**New FQHC/RHC Payment Provisions**

BIPA amends section 1902(a) of the Social Security Act by repealing the reasonable cost-based reimbursement requirements for FQHC/RHC services previously at paragraph (13)(C) and instead requiring in paragraph (15) payment for FQHCs/RHCs consistent with a new prospective payment system (PPS) described in section 1902(aa) of the Act. Under BIPA, the new Medicaid PPS takes effect on January 1, 2001.

In the first phase of the new Medicaid PPS (January 1, 2001-September 30, 2001), States are required to pay current FQHCs/RHCs 100 percent of the average of their reasonable costs of providing Medicaid-covered services during FY 1999 and FY 2000, adjusted to take into account any increase (or decrease) in the scope of services furnished during FY 2001 by the FQHC/RHC (calculating the payment amount on a per visit basis). Beginning in FY 2002, and for each fiscal year thereafter, each FQHC/RHC is entitled to the payment amount (on a per visit basis) to which the center or clinic was entitled under the Act in the previous fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the FQHC/RHC during that fiscal year. Newly qualified FQHCs/RHCs after fiscal year 2000 will have initial payments established either by reference to payments to other clinics in the same or adjacent areas, or in the absence of such other clinics, through cost reporting methods. After the initial year, payment shall be set using the MEI methods used for other clinics.

The new Medicaid PPS requirements are effective in all States with respect to services furnished by FQHCs/RHCs on or after January 1, 2001. Therefore, States must submit conforming State plan amendments before the end of the first calendar quarter.

**Alternative Payment Methodologies**

For the period beginning January 1, 2001 and ending September 30, 2001, and for any fiscal year beginning with FY 2002, a State may, in reimbursing an FQHC or an RHC for services furnished to Medicaid beneficiaries, use a

methodology other than the Medicaid PPS, but only if the following statutory requirements are met. First, the alternative payment methodology must be agreed to by the State and by each individual FQHC or RHC to which the State wishes to apply the methodology. Second, the methodology must result in a payment to the center or clinic that is at least equal to the amount to which it is entitled under the Medicaid PPS. Third, the methodology must be described in the approved State plan.

### **States with Section 1115 Waivers of FQHC/RHC Cost-Based Reimbursement**

A number of States currently have section 1115 waivers of the FQHC/RHC cost-based reimbursement provisions under section 1902(a)(13)(C) of the Social Security Act as it existed prior to enactment of Medicaid PPS. As discussed above, BIPA repealed these provisions and established a new PPS in sections 1902(a)(15) and 1902(aa) of the Act. Thus, the waivers of section 1902(a)(13)(C) are no longer extant. All States, including those operating section 1115 waiver demonstration programs, are subject to the new Medicaid PPS requirements in sections 1902(a)(15) and 1902(aa) of the Act.

### **Supplemental Payments to Managed Care Subcontractors**

In many States, Medicaid Managed Care Entities (MCEs) subcontract with FQHCs/RHCs to furnish covered services to Medicaid enrollees. As was the case under the law in effect prior to January 1, 2001, BIPA requires States to make supplemental payments to FQHCs/RHCs that subcontract (directly or indirectly) with MCEs representing the difference, if any, between the payment received by the FQHC/RHC for treating the MCE enrollee and the payment to which the FQHC/RHC would be entitled for these visits under the Medicaid PPS provisions of BIPA. The State must determine if the Medicaid PPS reimbursement to which the FQHC/RHC is entitled exceeds the amount of payments received by the FQHC/RHC and, if so, it must pay the difference to the FQHC/RHC. The State plan should be amended to include a description of the supplemental payment methodology.

If you have questions regarding this policy guidance, please contact Mike Fiore on 410-786-0623 or Suzan Stecklein on 410-786-3288.

Sincerely,  
/s/  
Timothy M. Westmoreland  
Director

cc:  
HCFA Regional Administrators  
HCFA Associate Regional Administrators For Medicaid and State Operations  
Lee Partridge, Director, Health Policy Unit - American Public Human Services Association  
Joy Wilson, Director, Health Committee - National Conference of State Legislatures  
Matt Salo, Director of Health Legislation - National Governors' Association  
Brent Ewig, Senior Director, Access Policy - Association of State and Territorial Health Officials

