

Legal Requirements and Issues Concerning Wraparound Payments to FQHCs

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This document reviews the legal provisions in the Federal Medicaid statute that require “wraparound” payments to Federally qualified health centers (FQHCs) for services provided to their Medicaid managed care patients, and highlights recent developments in this payment process that can adversely impact centers and may become particularly problematic in FQHC payment reform scenarios.¹

A. The Medicaid Act – Pre-wraparound

In 1989, when Congress created the FQHC benefit in Medicaid, it imposed an obligation on state Medicaid agencies to pay an FQHC 100 percent of its “reasonable costs,” following, to some degree, Medicare’s reasonable cost payment methodology. In those states that were already operating Medicaid managed care programs or that subsequently initiated these programs—through section 1115 waivers or section 1915(b) managed care waivers—FQHC reasonable cost payment often became a casualty of state/managed care organization (MCO) contracting. In some states, the MCOs might maintain that they were not required in their contract to calculate or pay reasonable cost to FQHCs or that they did not receive additional funds from the State to cover these costs. Others simply refused to contract with an FQHC if the FQHC insisted on these additional payments.

MCOs, in these cases, may have preferred not to contract with FQHCs because of the complications of paying them reasonable cost in a managed care payment system or may not have been provided additional funding from the State to cover these costs or might have received additional funding which they preferred to hold on to rather than contracting with FQHCs. States, on the other hand, did not want to oversee the FQHC payment requirements in Medicaid managed care arrangements, since a major consideration in their contracting with MCOs was that the MCO would handle contracting and payments to providers and the State would be responsible only for paying to the MCO a fixed amount for its services and costs. The result of these conflicting priorities was that MCOs would often offer contracts to FQHCs on a “take it or leave it basis” based on the same payment amounts they were paying their other providers and States would often fail to require MCOs to do otherwise.

CMS’ (then-HCFA) response to this problem in the early years of FQHC implementation and managed care expansion, was to maintain that an FQHC should be paid reasonable cost in managed care if the FQHC sought such payment in its negotiations with the MCO. But this was a “Catch-22” for many centers as they were often reluctant to seek this payment because they were concerned that the MCO would then refuse to contract with them—and there was clear and well-based concern that neither the state nor CMS would then step in and require the MCO to contract with

¹ This article borrows from, and contains excerpts from, a draft Issue Brief written for NACHC in June 2013 by Matt Freedus, an attorney with Feldesman Tucker Leifer Fidell.

the FQHC. As a result, in many cases, FQHCs in the managed care system were not paid the rate required by the Medicaid statute.

B. The FQHC Wraparound Requirement in the Medicaid statute

After hearing significant concerns from the health centers that in managed care they were not being paid as required by Medicaid federal law, Congress addressed this issue in 1997. The Balanced Budget Act (“BBA”) of 1997 added two provisions intended to solve the FQHC managed care payment problem. First it eliminated the MCOs’ financial responsibility to pay the FQHCs their special FQHC rate and instead required MCOs to pay FQHCs “not less” than they would pay non-FQHC providers for the same medical services². This provision essentially eliminated the financial disincentive for MCOs to contract with FQHCs.

To assure that FQHCs, nonetheless, were reimbursed the reasonable cost amounts that Medicaid law continued to require they be paid, the 1997 statutory amendments provided that states must pay a direct “supplemental payment [to FQHCs] equal to the amount . . . by which” an FQHC’s reasonable costs “exceed[ed] the amount of payments” FQHCs received from MCOs.³ For example, if the MCO paid an FQHC \$100 for a Medicaid managed care visit and the reasonable costs incurred by the FQHC were \$150, then the states is required to make a supplemental payment of \$50. The BBA’s terminology of “supplemental payment” has become commonly known as “wraparound.”

C. Implementation of BBA Wraparound

CMS did not issue federal regulations implementing the BBA’s FQHC wraparound requirements, however in 1998 CMS issued two State Medicaid Director Letters (“SMDLs”) advising States on the purpose and intent of the FQHC payment provisions in the 1997 BBA.

In particular, the first of the two letters, dated April 20, 1998, states that the 1997 BBA prohibits States from delegating their payment obligation to MCOs:

“Section 4712(b)(2) requires that rates of payment between FQHCs/RHCs and MCOs shall not be less than the amount of payment for a similar set of services with a non-FQHC/RHC. The intention of this provision is to ensure that managed care entities negotiate rates of payment with FQHCs and RHCs that are comparable to the rates paid to similar providers that do not have an FQHC or RHC designation and thereby protects the State against negotiated rates that are excessively low in comparison to the community standard.”

Similarly, the SMDL prohibits states from requiring MCOs to pay FQHCs at a higher (than what they pay other providers) rate, concerned that it would be contrary to Congressional intent to “remove financial barriers to this contracting” between MCOs and FQHCs.

This SMDL also makes the state, not the MCO, the entity that must “determine any differences in payment” between the MCO’s payment and the required cost-related payment to which the FQHC is entitled. And it is the state,

² 42 U.S.C. § 1396b(m)(2)(A)(ix) (1997) <http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap7-subchapXIX.htm>

³ 42 U.S.C. § 1396a(a)(13)(C) (1999) <http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap7-subchapXIX-sec1396a.htm>

not the MCO, which must then make any required supplemental payments. In that same letter, CMS states that “this requirement cannot and should not be delegated to an MCO...”

CMS issued a second SMDL, on October 23, 1998,⁴ to clarify the prohibition on higher payments to MCOs. The additional guidance was prompted by proposals from several states to include an estimated value of FQHC reasonable costs in the MCO capitation and then obligate the MCOs to pay the FQHCs the 100% reasonable cost reimbursement. CMS stated in this second guidance that such methods “are not consistent with the BBA.”

That second letter reiterates CMS’s position that MCOs should not be “involved in any issues regarding supplemental payments, reconciliation or other reimbursement issues that would raise payment levels between the two parties above those of non-FQHC/RHCs that provide a similar set of services.” In other words, CMS views the “pay not less than” requirement⁵ as a “prohibition of requirement for higher payments by MCOs,” that precludes a state from “impos[ing] any requirement on MCOs for payments to FQHCs/RHCs other than those contained in 4712(b)(2)” providing for payment comparable to other providers for similar services .

About three years after issuing the two State Medicaid Director Letters, CMS amended its Medicaid managed care regulations to implement provisions of BBA 1997. In the preamble to those amendments, CMS stated that there was no need to promulgate a regulation to implement the MCO’s FQHC payment obligation because it is “straightforward and self-implementing,” and CMS (then-HCFA) had already made known its interpretation of that requirement through the 1998 SMDLs. Moreover, CMS stressed that its interpretations of the MCO payment requirement, as expressed in those letters, are “enforceable, and entitled to deference from courts.”⁶

D. BIPA Maintains the FQHC Wraparound Requirement But Allows for an Alternative Payment Methodology (APM).

Congress again amended the FQHC payment provisions through the Benefits Improvements and Protections Act of 2000 (“BIPA”). The major change in FQHC payment that is found in BIPA is the implementation of the Prospective Payment System(PPS) in place of “reasonable cost payment,” but BIPA essentially left intact the two relevant FQHC/managed care requirements of the BBA that MCOs pay FQHCs no less than they would pay other providers for similar services and that states wrap-around the difference in payments to the FQHC. The relevant wraparound language in BIPA, which remains in the Medicaid statute as 1902(bb)(5)today, provides:

(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)[relevant FQHC PPS payment sections] 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 months⁷.

⁴ Both the April 20, 1998 and the October 23, 1998 State Medicaid Director Letters are available online at

<http://www.medicaid.gov/Federal-Policy-Guidance/federal-Policy-Guidance.html>.

⁵ 42 U.S.C. § 1396b(m)(2)(A)(ix) <http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap7-subchapXIX-sec1396d.pdf>

⁶ 66 Fed. Reg. 6373 (January 19, 2001)

⁷ 42 U.S.C. § 1396a(bb)(5)

The FQHC wraparound provision in the Medicaid statute, however does not appear to prohibit a state from delegating managed care wraparound to MCOs if it is carried out consistent with the FQHC alternative payment methodology (APM) provision in the Medicaid statute⁸. The broad language of the APM provision in the FQHC PPS payment section of the Medicaid statute, provides in pertinent part:

(6) 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 1396d (a)(2)(C) of this title or to a rural health clinic for services described in section 1396d(a)(2)(B) of this title 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.

CMS reiterated the requirements for use of an APM in a State Medicaid Directors Letter issued in 2001(SMDL #01-014):

“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.”

The devil is in the details, however, with regard to using the APM to allow for full direct payment from MCOs to FQHCs. For example, in order to determine whether an APM meets these requirement, any approvable APM arguably should include a mechanism to determine the amount the FQHC would have received under PPS and the amount it did receive under the APM. If an APM results in the FQHC receiving less than it would have received under PPS, it would appear to be contrary to the requirements of the statute. Also, there appears to be lack of clarity from CMS as to what kind of requirements a state would have to meet to show that an FQHC was agreeable to full direct payments from an MCO. Would a contractual agreement with the MCO suffice? Or an agreement between the state and the FQHC? Some indication of CMS’s position on this issue can be found in a 2010 State Health Official letter (SHO#10-004) issued by CMS detailing PPS requirements in implementation of the Children’s Health Insurance Program Reauthorization Act of 2009. In that SHO letter, CMS notes that States “may accept an FQHC’s or RHC’s written assertion that the amount paid under the APM results in payment that at least equals the amount to which the FQHC or RHC is entitled under the PPS.”

E. Reemergence of the FQHC/Managed Care Payment Problem

Notwithstanding CMS guidances and the plain statutory language in the BBA and its reiteration in the BIPA, a number of states have eliminated wraparound by requiring MCOs to pay the full amount required under the State plan or delegating the responsibility to MCOs for determining which claims are valid for purposes of the State’s wraparound

⁸ 42 U.S.C. § 1396a(bb)(6)

obligation.⁹ These recent developments, while they may appear to be contrary to the clear requirement of the Medicaid statute, may not be subject to easy resolution either legally or practically—for a number of reasons:

- The wraparound provision requires that the state pay “a supplemental payment equal to the amount **(if any)** by which the amount determined” to be payable under PPS exceeds the amount paid to the center by the MCO. Arguably, a state and/or CMS could maintain that the clause “(if any)” would allow for full payment by the MCO, that is, that Congress might have intended to allow for a situation where the state has provided sufficient funding through the MCO for the latter to fully cover the funds owed the FQHC without the need for a supplemental payment.
- CMS appears to have backed away for its earlier policies clearly stated in its 1998 SMDLs regarding states being prohibited from essentially delegating wrap-around payment to the MCOs. A departure from longstanding SMDLs that interpret the Medicaid Act as prohibiting the delegation of wraparound policy on the SMDLs might be unlawful as these SMDLs have not been formally rescinded and remain posted on the CMS website¹⁰.
- In some instances, FQHCs and PCAs may be supportive of their state’s having delegated full payment from MCOs in place of wraparound since wraparound payments from the states to FQHCs are often long delayed (despite the Medicaid statute’s requirement that they be paid no less frequently than every four months). For purposes of cash flow, centers in some states may prefer a more timely payment in the form of an enhanced payment from an MCO than a better but long over-due wraparound payment from the state.
- Related to the previous paragraph, an FQHC and a State could agree to an APM which would provide for full payment from the MCO rather than wraparound from the state. If this APM results in the MCO paying the FQHC less than what it would have been reimbursed under PPS, the state would appear to be in violation of the APM requirements and should ultimately be responsible for making the center whole for the difference between what the MCO paid the center and what the center would have received under PPS. With regard to an APM, the FQHC should make sure that it has an opportunity to agree to or reject the proposal, and that the proposal includes a mechanism that allows the state to determine whether the FQHC receives the full amount it is entitled to under PPS and a method by which the FQHC receives its full PPS. In other words, if at the end of the period in question the APM resulted in the FQHC receiving less than it would have received under PPS, the APM should make clear how the FQHC is to be made whole

Particularly relevant to Medicaid FQHC payment reform is a further complication that can develop in FQHC/managed care/wraparound reimbursement. The state, the MCO and the FQHC may find themselves in a three-way battle (four-way if CMS becomes involved) when there is some dispute as to whether the payment received by the FQHC from the MCO was for FQHC services provided by the FQHC, or was for non-FQHC services that the FQHC has agreed to provide under its contract with the MCO, or was for shared savings per the contract between the MCO and the FQHC, or was some other form of additional payment due the center from the MCO as a result of some other form of risk arrangement entered into between the MCO and the FQHC.

Some states may be inclined to treat any payment from the MCO to an FQHC as payment that must be included in calculating the amount the state owes the center in wraparound. This would not be consistent with the PPS wraparound provisions in the Medicaid statute and Congressional intent behind this provision—which was clearly to insure that the center received no less than a PPS amount when it provided FQHC services to Medicaid managed care patients. CMS appeared to recognize the distinction between payment to FQHCs for FQHC services and other payments to the FQHC from the MCO, when it stated that payments by a MCO to a FQHC as part of a shared savings arrangement

⁹ According to NACHC’s “2014 Update on Implementation of the FQHC Prospective Payment System (PPS) in the States” PCAs in 6 states (CA, CO, GA, MA, TX, and WV) reported that wraparound was “facilitated by MCOs” (rather than by their state Medicaid agency).

¹⁰ Administrative Procedure Act. 5 U.S.C. § 553 *et seq.*

would not be treated as payment to the FQHC for purposes of calculating wraparound owed the center from the state¹¹. Nonetheless, this issue of what payments to an FQHC from an MCO do or do not get factored into wraparound payments is likely to crop up frequently in future Medicaid CMS/State /FQHC payment reform deliberations—and should be dealt with up front so as to avoid future payment disputes between the parties.

¹¹ See SMDL of Sept.27, 2000 and Q/A No. 38 in CMS Guidance of Sept.12, 2001 <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd092700.pdf> and <https://www.nachc.com/client//PPS%20Q%20%20A%27s%20%282001%29.pdf>.

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