State Policy Report #24: Current FQHC-Specific Language in Medicaid 1115 Waivers and State Plan Amendments

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Compilation of Current FQHC-Specific Language in Medicaid 115 Waivers and State Plan Amendments, January 2009

Florida—Special Term and Condition No. 86:

Contracting with Federally Qualified Health Centers (FQHCs). Prior to the start date of the demonstration, the State will review health plan and physician capacity to ensure that it is adequate to serve the expected enrollment as part of the ongoing monitoring of the demonstration. The State will require plans, to make a good faith effort to include Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and County Health Departments (CHDs) in their network. If a plan can demonstrate to the State and CMS that both adequate capacity and an appropriate range of services for vulnerable populations exists to serve the expected enrollment in all service areas without contracting with FQHCs, RHCs, or CHDs, the plan can be relieved of this requirement. The State shall evaluate the number of FQHCs,RHCs and CHDs that contract with plans and make this information available to CMS upon request.

Hawaii–Special Term and Condition No. 27:

Contracting with Federally Qualified Health Centers (FQHCs). The state must require health plans to contract with FQHCs. If an MCO can demonstrate to CMS and to the Hawaii Department of Human Services that both adequate capacity and appropriate range of services for vulnerable populations exist to serve the expected enrollment in all service areas without having to contract with FQHCs, the plan may, with CMS Regional Office approval, be relieved of this requirement.

Kansas

B. Description of Benefits
1. Benchmark Benefits
d. Secretary Approved Coverage
Following are services provided under the Benchmark Benefits/Secretary-approved coverage that are the same as offered under the Medicaid State Plan: Rural Health Clinic Services, Limitations of Federally Qualified Health Centers

Kentucky **(Partnership waiver-only applies to Louisville and surrounding counties)**

30. Contracting with Federally Qualified Health Centers (FQHC) The state shall require health plans to contract with FQHCs. If an MCO can demonstrate to the United States Department of Health and Human Services and to the Kentucky Cabinet for Health and Family Services that both adequate capacity and an appropriate range of services for vulnerable populations exist to serve the expected enrollment in all service areas without contracting with FQHCs, the plan may, with CMS approval, be relieved of this requirement. For any Partnership that requests an exemption from the requirement that it contract with FQHCs, the state shall submit to CMS a report with the following information at least 60 days prior to submission of the final managed care contract for CMS approval:
a) The FQHCs in the Partnership's service area, and a description of the demonstration populations served and the services provided by the FQHCs prior to the demonstration.

b) An analysis that the Partnership has sufficient provider capacity to serve the demonstration populations currently receiving services at the FQHC. The analysis should include, but not be limited to, a listing of providers signed with the Partnership, capacity of each provider to take on additional Medicaid patients, geographic location of providers and description of accessibility for Medicaid patients to these providers. The Partnership must inform the state if any of this information or data changes over the course of the demonstration.
c) An analysis that the Partnership will provide a comparable level of Medicaid services as the FQHC (as covered in the approved State Medicaid plan), including covered outreach, social support services, and the availability of culturally sensitive services, such as translators and training for medical and administrative staff. The analysis should describe the proximity of providers, and range of services as it relates to FQHC patients, to the extent these services are currently available through FQHCs in the service area.
d) The Partnership will pay the FQHC(s) on either a capitated (risk) basis (with appropriate adjustments for risk factors) or on a cost-related basis. A description of the payment methodology shall be provided by the state. If during the demonstration, the Partnership changes its payment methodology to an FQHC, the changes must be submitted by the state to CMS for review and approval. (from CMS terms & conditions approved 10/25/05)

6. Payment of FQHCs and RHCs Section 1902 (bb) and Section 1902 (a)(15)
To enable Kentucky to not be required to pay FQHCs and RHCs in the Partnership under a prospective payment system, and to enable the state to not be subject to supplemental payments to FQHCs and RHCs. (from CMS waiver list approved 10/25/05)

Massachusetts- Special Terms and Conditions (6/19/2007)*Note: This is the last available version that is available on the MA Medicaid website, a new document is in the process of negotiation.

Safety Net Care Pool and Commonwealth Care Health Insurance Program (CHIP)

26. Allowable SNCP Payments. Payments from the SNCP may include unreimbursed Medicaid costs, inpatient hospital expenditures for the uninsured/SNCP population, outpatient hospital expenditures for the uninsured/SNCP population, and other non-hospital medical service expenditures for the uninsured/SNCP population (e.g. clinic, FQHC, physician), infrastructure expenditures subject to the limitations defined in subparagraph (a) below, expenditures for designated health programs as identified and limited by STC 27(b) and expenditures for the Commonwealth Care Health Insurance Program (C-CHIP), premium assistance program developed by Massachusetts and approved by CMS.

General Financial Requirements Under Title XIX

7. MassHealth Demonstration Program Expenditures. The MEG described in paragraph 5(m) above includes expenditures authorized under the Safety Net Care Pool. These expenditures will include inpatient hospital expenditures for the uninsured population, outpatient hospital expenditures for the uninsured population, and other non-hospital medical service expenditures for the uninsured population (e.g. clinic, FQHC, physician), infrastructure expenditures subject to the limitations defined in Attachment C, and any expenditures related to new insurance products, including premium assistance, that may be developed by Massachusetts and approved by CMS.

Section 3.5 Federal Qualified Health Center (FQHC) Payment Selective Contracting.

FQHCs participate as providers in the PCC Plan. FQHCs participating as PCC providers are reimbursed on a fee-for service basis.

Section 3.4.2 Coordination of Services

FQHCs- Currently, all but one MassHealth MCO (Fallon) contracts with at least one FQHC.

New York

DELIVERY SYSTEMS

23. Contracts. Procurement and the subsequent final contracts developed to implement selective contracting by the State with any provider group shall be subject to CMS approval prior to implementation. Existing contracts with Federally Qualified Health Centers (FQHC) shall continue in force.

Oklahoma

SoonerCare

I. Federally Qualified Health Centers (FQHCs)

1. a. The State shall as a general rule require MCOs and Outpatient Networks to contract with FQHCs in their service area. However, if the State can demonstrate to HCFA that the plans have adequate capacity and will provide an appropriate range of services for vulnerable populations without contracting with an FQHC in its service area, the MCO/Outpatient Network can be relieved of this requirement.

   b. For any MCO/Outpatient Network that request an exemption from the requirement that it contract with FQHCs, the State shall submit to HCFA a report with the following information at least 60 days prior to submission of the final managed care contract for HCFA approval:

   1. The FQHCs in the MCO/Outpatient Network's service area, and a description of the demonstration populations served and the services provided by the FQHCs prior to the demonstration.
   2. An analysis that the MCO/Outpatient Network has sufficient provider capacity to serve the demonstration populations currently receiving services at the FQHC. The analysis should include, but not be limited to, a listing of providers signed with the MCO/Outpatient Network, capacity of each provider to take on additional Medicaid patients, geographic location of providers and description of accessibility for Medicaid patients to these providers. The MCO/Outpatient Network must inform the State if any of this information or data changes over the course of the demonstration.
   3. An analysis that the MCO/Outpatient Network will provide a comparable level of Medicaid services as the FQHC (as covered in the approved State Medicaid plan), including covered outreach, social support services, and the availability of culturally sensitive services, such as translators and training for medical and administrative staff. The analysis should describe the proximity of providers, and range of services as it relates to FQHC patients, to the extent these services are currently available through FQHCs in the service area.

c. The MCO/Outpatient Network will pay the FQHC(s) on either a capitated (risk) basis (with appropriate adjustments for risk factors) or on a cost-related basis. A description of the payment methodology shall be provided by the State. If during the demonstration, the MCO/Outpatient Network changes its payment methodology to an FQHC, the changes must be submitted by the State to HCFA for review and approval.

ESI expansion (approved for 10/1/05-12/31/06)

5. Access to FQHCs and RHCs Section 1902(a)(10)(A)

To enable the state to authorize provision of alternatives to FQHC services, and to RHC services.

Oregon

Payment of FQHCs and RHCs-Section 1902 (a)(10)
To enable the State to offer FQHC and RHC services only to the extent available through managed care providers.

Rhode Island

Costs Not Otherwise Matchable:
13. Expenditures for payments to health plans for performance incentives; risk sharing; and stop loss, as well as FQHC supplemental payments (budget services 3)

15. Expenditures not to exceed $1.2 million for payments to Federally Qualified Health Centers (FQHCs) for general infrastructure support.

(from 12/16/2008 CMS Waiver Expenditure Authority)

Tennessee

FQHCs & RHCs Benefit-Section 1902 (a)(10)
To enable the State to permit managed care contractors to limit coverage of FQHC and RHC services when CMS and the State have determined that equivalent services are available and accessible in other covered settings.

Utah

FQHCs-1902 (a)(15) and 1902 (aa)
To permit the State to pay for federally qualified health center services provided to Demonstration Population I participants on a basis other than a prospective payment system.

Vermont

29. **Contracting with Federally Qualified Health Centers (FQHCs).** The State shall maintain its existing agreements with FQHCs and rural health centers. Reimbursement for services provided to individuals enrolled in ESI/Premium Assistance programs shall be based on requirements established by the Vermont 2006 Health Care Affordability Act and the terms contained in the independent agreements reached between FQHCs/rural health centers and participating carriers. (from CMS Vermont Global Commitment to Health 2007 Premium Assistance Amendment Approval Letter)

For the complete waiver documents, go to the State Policy Page of the NACHC website.
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