

# Supplemental Payments to FQHCs for Services Provided Under Medicaid Managed Care



States pay federally-qualified health centers (FQHCs or “health centers”) under Medicaid using a prospective payment system (PPS), effective for services rendered on or after January 1, 2001. The Medicaid FQHC PPS, set forth in Section 1902(bb) of the Social Security Act (SSA), is a bundled, prospective, cost-related payment methodology covering a comprehensive range of services furnished by FQHCs. FQHCs are paid a fixed per-visit rate reflecting 100% of the center’s reasonable costs of furnishing covered services during a base period (Fiscal Years (FYs) 1999 and 2000).

Today, Medicaid managed care is expanding rapidly nationwide, with 68% of Medicaid beneficiaries enrolled in comprehensive managed care in 2016, up from 51% in 2011.<sup>1</sup> FQHCs are critical safety-net providers of a broad range of outpatient services in the Medicaid program. FQHC services are a required benefit in Medicaid for categorically needy individuals, and Medicaid is most health centers’ largest payor.<sup>2</sup> Consequently, policy issues concerning the intersection of managed care and the PPS system are prominent for FQHCs.

The federal law addressing the Medicaid FQHC PPS contains special provisions regarding payments to FQHCs for services rendered under contract with a Medicaid managed care organization (MCO). In essence, states are required to make payments to FQHCs to cover the difference between amounts paid to the FQHC by a Medicaid managed care organization (MCO) and the FQHC’s PPS rate (if the latter is higher).<sup>3</sup> These supplemental payments, which are made directly from the state to the FQHC, are sometimes referred to as “wraparound” payments.

This Issue Brief provides an overview of the law relating to wraparound payments to FQHCs, and identifies several current key policy issues relating to FQHCs’ participation in Medicaid managed care.

## The FQHC Wraparound Requirement in the Medicaid Statute

The federal law governing the Medicaid FQHC PPS, which was enacted as part of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (“BIPA”), contains the following provision relating to services furnished under 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 [the PPS methodology] 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.<sup>4</sup>

This “wraparound” requirement for FQHCs is unique in the Medicaid program. In general, Medicaid providers receive only the payments they negotiate with the MCO if they choose to participate in managed care. The FQHC wraparound requirement, which predates the 2001 law that implemented the FQHC PPS, originates from a concern by Congress, in the words of the Centers for Medicare & Medicaid Services (CMS), “to encourage contracting between FQHCs/RHCs and MCOs and to remove financial barriers to this contracting.”<sup>5</sup>

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<sup>1</sup> HHS, CMS, Medicaid Managed Care Enrollment and Program Characteristics, 2016 (Spring 2018), Table 4 (p. 20), at <https://www.medicare.gov/medicaid/managed-care/downloads/enrollment/2016-medicare-managed-care-enrollment-report.pdf>; HHS, CMS, Medicaid Managed Care: Trends and Snapshots, 2000-2013, Figure 2 (p. 8), at <https://www.medicare.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2013-medicare-managed-care-trends-and-snapshots-2000-2013.pdf>. “Comprehensive managed care” refers to a contractual arrangement between a State and a managed care organization (MCO) for the MCO to provide for a comprehensive range of services for enrollees.

<sup>2</sup> Social Security Act (SSA) § 1902(a)(10)(A) (FQHC services required Medicaid benefit). According to 2017 Uniform Data System information gathered by the Health Resources and Services Administration (HRSA), Medicaid accounted for approximately 66% of health center grantees’ total collections from payors that year. Medicaid and children’s Health Insurance Program (CHIP) beneficiaries accounted for approximately 49% of total health center grantee patients in 2017. See HRSA, Program Grantee UDS Data, 2017 (tables 9C and 4), at <https://bphc.hrsa.gov/datareporting/index.html>.

<sup>3,4</sup> SSA § 1902(bb)(5).

<sup>5</sup> CMS, State Medicaid Director Letter, Apr. 20, 1998, re: Changes in Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Requirements Stemming from the Balanced Budget Act of 1997.

The requirement is intended to ensure that FQHCs are not forced to give up the cost-related PPS rate (or alternative payment methodology (APM) rate) that they would receive in fee-for-service Medicaid, in order to be able to serve managed care populations.

While there are no implementing Medicaid regulations for the FQHC PPS, a September 2001 guidance from the Centers for Medicare & Medicaid Services (CMS) interpreting the Medicaid FQHC PPS provisions in BIPA (“the 2001 PPS Guidance”) clarified some aspects of the statutory wraparound provisions. For example, CMS noted that in addition to making supplemental payments at least every four months, states must “perform a reconciliation at least annually, or more often at the state option, to ensure that MCO payments plus state supplemental payments” to FQHCs equal the amount under the PPS.<sup>6</sup> The guidance also specified that each State’s Medicaid State plan should include a methodology for calculating supplemental payments and a timeline for payment.

Under federal law, states may choose to use an alternative payment methodology (APM) instead of the FQHC PPS. However, a state’s payments to FQHCs under an APM must be at least equal to what an FQHC would have received under the PPS, and in addition, states may enforce an APM only if the affected FQHC agrees to it.<sup>7</sup> The 2001 PPS Guidance clarified that where health centers have elected an APM that results in payments higher than under the PPS, the state must make managed care wraparound payments up to the APM rate—not the lower PPS rate.

Five current policy trends involving Medicaid FQHC wraparound payments are described below.

### Timeliness of Wraparound Payments

Timely and full payment of wraparound is a concern for FQHCs in many states. The law, at SSA Section 1902(bb)(5)(B), requires states to make supplemental payments to FQHCs “in no case less frequently than every 4 months.” The 2001 PPS Guidance also requires states to conduct an annual reconciliation to ensure that managed care supplemental payments are fully compensatory as required by the law.

In some instances, states do not provide a fully compensatory supplemental payment to the FQHC within the 4-month timeframe for wraparound payments. Such delays are particularly common in states that use APMs that provide for cost-based reimbursement. Under such a methodology, FQHCs file annual Medicaid cost reports. Per-visit payments are typically made on a provisional basis, pending settlement of the cost report.

For states using retrospective cost-based APMs, managed care supplemental payments typically form part of the cost report settlement. Managed care wraparound payments may lag for years if the cost report settlement process is delayed. States have an obligation to reconcile those supplemental payments on a regular basis to the full PPS or APM rate in a timely manner (at least annually).

In states where wraparound delays are common, FQHCs and primary care associations (PCAs) can request rules that hold the state accountable to the timelines in the federal law. State rules should also provide for a meaningful appeal process allowing FQHCs to contest wraparound payments that are not fully compensatory, or to object to delay by the state in processing wraparound payments.

### “Paid Claims” Policies

Some states, as a matter of either stated policy or in practice, consider an FQHC visit furnished under contract with an MCO to be eligible for a supplemental payment only if the MCO has already paid a claim relating to the visit. Two federal appeals courts have held that such policies (“paid claims” policies), as implemented in New York and New Jersey, violated Section 1902(bb)(5) of the SSA by making the FQHC’s entitlement to supplemental payment contingent upon payment of a claim by an MCO.<sup>8</sup>

The more legally sound approach is for a state to make a wraparound payment to an FQHC relating to any visit furnished under managed care that meets all applicable requirements for payment under fee-for-service Medicaid—regardless of whether an MCO paid a claim on the visit. As one court noted, MCOs often deny payments for “reasons unrelated to Medicaid.” The result is that the Medicaid wraparound payments “inevitably exclude valid, Medicaid-eligible encounters and result in underpayment.”<sup>9</sup> Another court stated that paid claims policies are faulty because these policies “make the MCO the ultimate arbiter” of whether services furnished by an FQHC under Medicaid managed care are billable—when the state should be the arbiter.

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

<sup>7</sup> Social Security Act (SSA) § 1902(bb)(6).

<sup>8</sup> *New Jersey Primary Care Ass’n, Inc. v. New Jersey Dep’t of Human Servs.*, 722 F.3d 527 (3d Cir. 2013); *Community Health Care Ass’n of New York v. Shah*, 770 F.3d 129 (2d. Cir. 2014).

<sup>9</sup> *New Jersey Primary Care Ass’n, Inc. v. New Jersey Dep’t of Human Servs.*, 722 F.3d at 541.

There are many reasons that MCOs may deny claims that are unrelated to whether the billed service constituted a valid FQHC “visit” for purposes of Medicaid payment. For example, claims may be denied because the MCO determined (correctly or erroneously) that the patient served had another form of insurance, or because the provider did not comply with specific coding or billing requirements imposed by the MCO. Nonpayment, of course, may also result from errors in the MCO’s claims processing systems.

Optimally, states should not restrict supplemental payments to those visits on which the MCO has already paid a claim. However, if a state does persist in using a “paid claims” policy, the policy can be made more compliant with the federal law by implementing an administrative process by which an FQHC may “promptly and effectively challenge an adverse MCO determination” for purposes of the entitlement to supplemental payment.<sup>10</sup>

### Treatment Of Incentive Compensation from MCO to FQHC

Increasingly, states are encouraging or requiring Medicaid MCOs to use value-based payment (VBP) in their arrangements with network providers. VBP generally refers to activities that move away from a traditional fee-for-service payment system to models that reward high-quality, cost-effective care.

VBP arrangements between FQHCs and MCOs add new complexity to the computation of wraparound payment. At its most basic level, wraparound payment is typically determined as follows:

$$\text{Wraparound} = \text{Total visits X PPS (or APM) Rate, less MCO payments received}$$

The assumption behind this formula is that payments from the MCO to the FQHC are compensation for services rendered under the provider agreement. Under an incentive payment arrangement, on the other hand, some payments are designed as rewards for achieving targets relating to various areas, such as infrastructure/operations, reporting requirements, or performance standards (based on health outcomes or care furnished). In the formula above, incentive payments, since they are not compensatory payments for contracted services, should not be included within “MCO payments received”—and therefore should not be offset from the total amount due to the FQHC under the PPS or APM for purposes of the wraparound calculation.

CMS’ 2001 PPS Guidance supports this conclusion. It reaffirmed September 2000 guidance that had preceded

the implementation of the PPS, stating that “incentive amounts (whether negative or positive) are separate from the MCO’s payment for services provided under the subcontract, do not include any additional Federal funding, and should not be included in the state’s calculation of supplemental payments.”<sup>11</sup>

### Payment for Out-of-Network Services

Medicaid managed care plans are typically organized on a network basis, meaning that in general, Medicaid MCO enrollees may be required to access care only from providers who contract with the MCO. However, federal law specifies several types of care that must be made available “out-of-network” to Medicaid MCO enrollees, including services that were provided to an MCO enrollee “other than through the [MCO] because the services were immediately required due to an unforeseen illness, injury, or condition.”<sup>12</sup> The state may either require the MCO to pay for such urgent out-of-network care, or the state may pay for it directly. Notably, the types of services that fall in this category correspond to health conditions that require urgent attention—a broader category than emergency care (another type of care that must be made available out-of-network).

FQHCs frequently see patients with urgent, unforeseen health concerns requiring immediate attention. The FQHC has an obligation to treat these patients, even if the patient is enrolled in a Medicaid MCO with which the FQHC is not a participating provider. Where FQHC treats an MCO enrollee out-of-network in this circumstance, the FQHC is nonetheless entitled to full payment.<sup>13</sup> The state may choose whether it wants to achieve this result by requiring MCOs to cover these out-of-network services (and furnishing wraparound on the MCO payments), or by providing for direct payment from the state to the FQHC for these services without involvement by the MCO.

<sup>10</sup> Id. at 543.

<sup>11</sup> Memorandum from Timothy M. Westmoreland, Health Care Financing Administration (now CMS), to State Medicaid Directors (Sept. 27, 2000) re: Policy Areas Pertaining to Federally Qualified Health Centers/Rural Health Clinics, p. 2, at <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd092700.pdf>.

<sup>12</sup> SSA § 1903(m)(2)(A)(vii).

<sup>13</sup> Cmty. Health Care Ass’n of N.Y. v. Shah, 770 F.3d 129, 157 (2d Cir. 2014); Three Lower Ctys. Cmty. Health Servs., Inc. v. Maryland, 498 F.3d 294, 304 (4th Cir. 2007).

## Contractual Delegation to MCO Of Full Medicaid Payment to FQHCs

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

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

There are risks inherent in such an arrangement. Chief among them, MCOs—because they receive payment through prepaid capitation amounts—could have an incentive either to exclude FQHCs from the network or to avoid paying FQHC claims through over-use of utilization controls. In this situation, the MCO would receive capitation rates reflecting the costs of covering FQHC services according to the PPS methodology, but it would not be making the FQHC benefit—a required Medicaid benefit—fully available to its enrollees.

In April 2016, CMS issued guidance on this topic, advising that states may require MCOs to pay contracted FQHCs the full PPS rate for covered services, provided that they meet various requirements.<sup>14</sup> Because the Medicaid statute requires direct wraparound payments from the state to the FQHC, states may delegate PPS

payment to MCOs only through a CMS-approved APM documented in the Medicaid State plan. CMS made clear that states "would remain responsible for ensuring that FQHCs and RHCs receive at least the full PPS reimbursement rate. States must continue their reconciliation and oversight processes to ensure that the managed care payments comply with the statutory requirements of the APM."

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

## Conclusion

To preserve their role as critical safety net providers in a Medicaid landscape increasingly dominated by managed care, FQHCs need to receive their full PPS rate for services furnished to managed care enrollees. FQHCs and PCAs should monitor states' adherence to the supplemental payment rules, and particularly, monitor the key issues identified in this Issue Brief.

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<sup>14</sup> State Health Official Letter # 16-006, from Vikki Wachino, Director, Center for Medicaid & CHIP Services, CMS (Apr. 26, 2016), re: FQHC and RHC Supplemental Payment Requirements, pp. 2-3, at <https://www.medicaid.gov/federal-policy-guidancfSte/downloads/smd16006.pdf>.

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