

SHO # 16-006

RE: FQHC and RHC Supplemental Payment Requirements and FQHC, RHC, and FBC Network Sufficiency under Medicaid and CHIP Managed Care

April 26, 2016

Dear State Health Official:

The purpose of this letter is to provide guidance on federally-qualified health center (FQHC) and rural health clinic (RHC) payment methodologies under both Medicaid and Children's Health Insurance Program (CHIP) managed care delivery systems. This letter also provides guidance on FQHC, RHC, and freestanding birth center (FBC) network sufficiency standards applicable to a Medicaid managed care delivery system. The guidance set forth in this State Health Official (SHO) letter applies to all Medicaid and CHIP managed care arrangements that provide capitated payment for outpatient services, including comprehensive plans offered by managed care organizations (MCOs) and prepaid ambulatory health plans (PAHPs), and with respect to FBCs, applies to prepaid inpatient health plans (PIHPs). This guidance does not apply to programs authorized under section 1115A of the Social Security Act (the Act).

For Medicaid, previous guidance on FQHC and RHC payment requirements was issued in 1998 and 2000 (available at: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD042098.pdf>, <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD102398.pdf>, and <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd092700.pdf>). Previous guidance for CHIP was provided in a February 4, 2010 State Health Official letter (SHO #10-004, available at: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO10004.pdf>). These letters are still valid regarding FQHC and RHC cost-based reimbursement; however, the Medicaid guidance was published before the enactment of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), which changed the required payment methodology for FQHC and RHC services. In addition, there have been continuing state delivery system changes as more states have moved to managed care options. As a result, the Centers for Medicare & Medicaid Services (CMS) believes further guidance is needed.

FQHC and RHC supplemental payment requirements under Medicaid managed care

Consistent with BIPA and section 1902(bb) of the Act, FQHCs and RHCs are entitled to receive payment for providing covered services to Medicaid-eligible individuals under a Prospective Payment System (PPS) methodology. The basic requirements for this methodology are set forth at sections 1902(bb)(2) through (4) of the Act, and as discussed below, at section 1902(bb)(6) of the Act, which includes an option for a state and an FQHC or RHC to agree to an alternative payment methodology (APM) that provides for payment of at least the same amount as would otherwise be required under the PPS.

Section 1902(bb)(5) of the Act, which applies to payments for FQHC and RHC services furnished through Medicaid managed care programs, requires that state plans provide for supplemental payments from states to FQHCs and RHCs equal to the amount or difference between the payment under the PPS methodology and the payment provided under the managed care contract. The purpose of this provision is to ensure that FQHCs and RHCs continue to receive their full PPS reimbursement rate regardless of the Medicaid delivery system, in light of the traditional flexibility for capitated managed care plans to set provider payment rates.

Consistent with section 1903(m)(2)(A)(ix) of the Act, managed care organizations that enter into contracts with FQHCs and RHCs must provide payments for services that are not less than the amount of payments that would be provided if those services were furnished by a provider that is not an FQHC or RHC. This statute does not prohibit managed care plans from paying higher rates to FQHCs and RHCs than would be paid to other providers. Read together, sections 1902(bb)(5) and 1903(m)(2)(A)(ix) of the Act provide the requirements for FQHC and RHC reimbursement when outpatient services are furnished under a Medicaid managed care delivery system.

Alternative payment methodology to simplify supplemental payments to FQHCs and RHCs

States, FQHCs, and RHCs have long stated that the supplemental payment requirements under section 1902(bb)(5) of the Act, as described above, have created many complex issues under Medicaid managed care programs, including reconciliation disputes and complaints regarding the timeliness of supplemental payments. States have expressed an interest in alleviating these issues and the complexity of supplemental payments to FQHCs and RHCs by requiring that managed care contracts provide FQHCs and RHCs the full PPS reimbursement rate for covered services.

To accomplish this goal, a state could amend its state plan to implement an APM, which is an optional alternative to the PPS requirements, including the supplemental payment requirements described above, as authorized under section 1902(bb)(6) of the Act. In order to use an APM to accomplish this goal, two conditions must be met: (1) the state and FQHC or RHC agree to use the APM; and (2) the APM results in FQHCs or RHCs receiving at least their full PPS

reimbursement rate from the managed care organization. If a state chooses to implement the APM, the state would have to include in its managed care contracts a requirement that managed care plans pay contracted FQHCs and RHCs at least the full PPS payment rate for covered services. In turn, the state would include the full PPS payment rate in calculating the actuarially sound capitation rates paid to managed care plans. This could simplify the process of paying FQHCs and RHCs for services furnished under the managed care contract overall and eliminate the general need for states to provide supplemental payments to FQHCs and RHCs for such services as required in section 1902(bb)(5) of the Act. Further, 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.

States interested in pursuing an APM for FQHCs and RHCs under Medicaid managed care programs must describe the payment methodology in their Medicaid state plan. States should be prepared to demonstrate that each affected FQHC and RHC has agreed to the APM.

CMS understands that some states may already be exercising an APM through Medicaid managed care plan contracts without the approved state plan amendment (SPA) pages described in this guidance. CMS urges such states to submit the appropriate SPA pages and come into compliance with section 1902(bb)(6) of the Act as soon as possible. After July 1, 2017, CMS will not approve a state's managed care contract in which FQHCs or RHCs are provided at least their full PPS reimbursement rate by managed care plans, unless the corresponding SPA pages have been approved by CMS, and the state has demonstrated that each affected FQHC and RHC has agreed to the APM. The state could also use a combination of both approaches, including state supplemental payments for some FQHCs and RHCs consistent with section 1902(bb)(5) of the Act, and the APM for other FQHCs and RHCs consistent with section 1902(bb)(6) of the Act.

Application to CHIP

The February 4, 2010 State Health Official letter (SHO #10-004) provides guidance on implementation of section 503 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Section 503 of CHIPRA amended section 2107(e)(1)(G) of the Act to require that separate CHIP programs use the Medicaid payment methodologies set forth in section 1902(bb) of the Act for all FQHC and RHC services provided on or after October 1, 2009, using one of three methods as described in SHO #10-004. The three methodologies for states to come into compliance with section 503 of CHIPRA were to (1) adopt the Medicaid PPS rates, (2) construct separate CHIP PPS rates, or (3) use an APM. For states that provide CHIP benefits through managed care contractors, and for which the contractor includes one or more FQHCs or RHCs in its network, the requirements for supplemental payments apply in the same manner as they do in Medicaid. States electing to contract with FQHCs and/or RHCs to provide CHIP-covered services, or in which a CHIP plan includes one or more FQHCs or RHCs

in its network, may use the APM for Medicaid described above to require FQHCs and RHCs to receive the full PPS payment through the managed care organization, and must submit a SPA to reflect this change. We expect that states will submit the appropriate SPA pages for their separate CHIPs and come into compliance with section 1902(bb)(6) of the Act under the same time frame as for their Medicaid programs – i.e., by July 1, 2017. CMS staff will be available to provide states that operate separate CHIPs with technical assistance regarding the requirements of developing an APM for FQHCs and RHCs which complies with section 1902(bb)(6) of the Act. We also will provide additional guidance regarding CMS review of managed care contracts for separate CHIPs.

The policies described in SHO #10-004 remain intact and continue to apply to separate CHIP programs. We note that the Medicaid requirements under section 1903(m)(2)(A)(ix) of the Act (which requires Medicaid MCOs to reimburse FQHCs and RHCs at a rate no less than other providers) do not apply to separate CHIP programs. However, states operating a separate CHIP program may want to consider including such a requirement in their MCO contracts for administrative simplicity and to strengthen the public safety net.

FQHC, RHC, and FBC network sufficiency under Medicaid managed care

States, managed care plans, and provider organizations have asked CMS to clarify the contracting requirements related to FQHCs, RHCs, and FBCs, as these benefit categories are considered both a service and a setting for services under section 1905(a) of the Act. Specifically, under sections 1905(a)(2)(B) and (C) and 1905(a)(28) of the Act, as well as sections 1905(l)(1) through (3) of the Act, FQHC, RHC, and FBC services are mandatory Medicaid benefits (including other ambulatory services offered by such facilities and otherwise included in the plan; RHC and FBC services are only mandatory to the extent the state licenses or otherwise recognizes such providers under state law). Additionally, section 1903(m)(1)(A)(i) of the Act requires a managed care organization to make the services it provides, within the area served by the managed care organization, accessible to the same extent as such services are made accessible under the Medicaid state plan to beneficiaries who are not enrolled in the managed care plan.

While CMS has encouraged the inclusion of FQHCs, RHCs, and FBCs in the networks of Medicaid managed care plans, in the past we have generally found provider networks to be sufficient as long as both states and managed care plans have assured adequate capacity and access to services for Medicaid managed care enrollees in at least one appropriate setting (which might not include FQHCs, RHCs, and FBCs for a particular managed care plan), and have required that at least one Medicaid managed care option available to enrollees includes FQHCs, RHCs, and FBCs. This policy was applied to ensure that, at a minimum, the individual services offered by FQHCs, RHCs, and FBCs were made available to all Medicaid managed care enrollees as a mandatory service under section 1905(a) of the Act.

CMS continues to focus on strategies to improve access to health care services for Medicaid beneficiaries and recognizes the increasingly important role of FQHCs, RHCs, and FBCs in ensuring access to needed care. To better ensure this access and to be consistent with the intent of sections 1905(a)(2)(B) and (C) and 1905(a)(28) of the Act, CMS has determined that, in order for a Medicaid managed care plan's provider network to be sufficient, the managed care plan must include access to FQHC, RHC, and FBC services, if available, from FQHCs, RHCs, and FBCs. Therefore, for managed care contracts starting on or after July 1, 2017 that include FQHC, RHC, or FBC services, CMS will not approve the contracts unless each managed care plan includes at least one FQHC, one RHC, and one FBC (to the extent the state licenses or otherwise recognizes RHC and FBC providers under state law) in the provider network, where available, for the managed care plan's contracted service area. When FQHC, RHC, and FBC services are not included under a state's managed care contracts, the services must be provided or arranged by the state directly. States retain the flexibility to require managed care plans to contract beyond this minimum standard. CMS believes this position appropriately balances the federal requirement to include FQHC, RHC, and FBC services as a mandatory Medicaid benefit and the flexibilities for states and managed care plans under Medicaid managed care in establishing provider networks. Furthermore, we believe that this position will promote access to needed care for Medicaid managed care enrollees.

Medicaid related questions regarding this guidance should be directed to John Giles, Health Insurance Specialist, at 410-786-1255 or via e-mail at John.Giles@cms.hhs.gov. CHIP related questions should be directed to Melissa Williams, Technical Director, via e-mail at Melissa.Williams3@cms.hhs.gov. We look forward to continuing our work together to strengthen Medicaid and CHIP managed care.

Sincerely,

/s/

Vikki Wachino
Director

cc:

National Association of Medicaid Directors
National Academy for State Health Policy
National Governors Association
American Public Human Services Association
Association of State Territorial Health Officials
Council of State Governments
National Conference of State Legislatures