SMDL #01-014
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

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