Medicaid Reimbursement

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

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History

- Since 1989 federal law has required Medicaid to pay FQHCs one hundred percent of its reasonable costs related to treating their beneficiaries.
- The purpose of this legislation was to prevent Public Health Service Act Section 330 grant money from being diverted from caring for individuals with no insurance and no means of paying for services.
- Medicaid payment for services was typically around seventy percent of costs incurred by the centers for treating Medicaid patients. Centers would cost settle at the end of each year for payment.
- In 2000, the passage of Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement Protection Act (BIPA) created the current Prospective Payment System (PPS). It was designed to reimburse FQHCs and Rural Health Clinics (RHCs), on a per visit basis, the cost of treating Medicaid beneficiaries.

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PPS Rate

- The rate was set by calculating all reasonable costs associated with providing Medicaid covered services to beneficiaries in Fiscal Year 1999 and 2000. The services included all FQHC/RHC services, as well as other ambulatory services included in the State Plan.
- The total was then divided by the aggregate number of billable visits. The rate calculation was submitted to the Medicaid agency for review and approval.
- Each year the rate was to be increased by the inflationary index called the Medicare Economic Index (MEI).
- Further, when a center or clinic added new services they could apply for a “change in scope” and have their PPS rate amended to include these additional costs and visits.
- These rates are calculated and approved by Medicaid through the submission of cost reports by the clinics and review of claims data from the first fiscal year of operations of the clinic.

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Managed Care

- In a managed care environment, the Medicaid agency still bears the responsibility of paying clinics and health centers the full PPS rate.
- The Managed Care Organization (MCO) is required to pay the clinic and health centers no less than they would any other provider for the same services on the fee schedule.
- In turn, the state is required to pay a “wrap around” or supplemental payment to the clinic if the fee schedule payment from the MCO is less than the clinic’s PPS rate. The law also requires this full payment to be made by Medicaid to the clinics and health centers no less than every four months.

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Current Payment Process

- FQHC/RHC bills a visit to the MCO.
- MCO pays the claim per the Medicaid Fee Schedule.
- The MCO submits the Encounter to the Department for Medicaid Services (DMS).
- The encounter must cross the “Threshold Editing” DMS has in place. If it fails any of these edits it is rejected and sent back to the MCO.
- If the claim gets through the editing process DMS will pay a supplemental payment to the provider which is calculated as follows: Clinic PPS Rate – MCO Paid Amount = DMS Supplemental Payment

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Current Payment Process (continued)

- If the claim fails the threshold editing process it is returned to the respective MCO for correct and resubmission.
- The clinics are not notified by the MCOs or DMS it has failed the editing process for DMS and was returned to the MCO.
- DMS only maintains reports of these returned encounters for a short time and they are not monitored for resubmission by DMS.
- It is up to the MCO to re-submit the encounter to DMS.
- This causes a multitude of problems for the clinics and DMS as well. (missing revenue due from DMS to clinics and incomplete data claims data for DMS)

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Resolution

- KPCA is asking to work with DMS to develop a system that would “reconcile” the claims submitted by clinics to MCOs and the supplemental payment made by DMS to the clinics. This includes utilization of a centralized data system being built by KPCA and additional funding as appropriate to aid in the process.
- Currently, only encounters paid by the MCO that make it across the “threshold” are paid the supplemental payment by DMS. This has caused substantial losses to our clinics dating back to 2014 because only one set of data exists to compare the claims.
- Most states have two sets of data to compare the claims submitted and claims paid to ensure compliance with the federal law full payment requirement.
- KPCA has done extensive research and retained outside legal counsel to provide DMS with reconciliation methodologies from different states for their review and consideration.

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