



Federally Qualified Health Centers: Medicaid and Medicare Reimbursement for the National DPP Lifestyle Change Program

This document is meant to serve as a companion piece to information presented on the National Diabetes Prevention Program Coverage Toolkit [Engaging Federally Qualified Health Centers](#) page.

1. What are Federally Qualified Health Centers (FQHCs)?

FQHCs are private or public non-profit health centers that receive grant funding from the Health Resources and Services Administration's (HRSA) Health Center Programⁱ and must meet five basic requirements: (1) be located in or serve medically underserved areas and populations;ⁱⁱ (2) provide comprehensive primary health care; (3) provide health care services to the entire community in which they serve; (4) only charge for services in accordance with the patients' ability to pay; and (5) be governed by a community board with a majority membership of health center patients.ⁱⁱⁱ

Federal law (Section 330 of the Public Health Service Act) requires FQHCs to provide certain services including, but not limited to:^{iv}

- Primary health care services
- Diagnostic laboratory and radiologic services
- Preventive health services such as prenatal and perinatal services, appropriate cancer screening, well-child services, preventive dental services, etc.
- Some urgent or emergency medical services
- Patient case management services
- Public health education services

Most FQHCs also provide access to pharmacy, mental health, substance use disorder, and oral health services in areas where economic, geographic, or cultural barriers limit access to affordable health care services. See [HRSA Health Center Program](#) and [Health Center Program Compliance Manual](#) for more information.

FQHCs receive payment and financial support from:

- Medicaid (in 2020, the Medicaid share of FQHC revenue ranged from 11% in Mississippi to 57% in Washington State. Nationally, Medicaid makes up 41% of FQHC patient revenue)^v
- Medicare (paid through the Medicare FQHC PPS). Note that the Medicare and Medicaid PPS rate methodologies are significantly different, see point #8 below and CMS guidance [SHO #10-004](#) for more information.

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- Private insurance
- Self-pay
- HRSA grants (HRSA grants, or Federal Section 330 Grants, are the grants provided by HSRA authorized under Section 330 of the Public Health Service Act)
- A variety of other grant funding sources (includes non-Section 330 federal grants, grants from state and local governments and private foundations, and other state and local government payments)^{vi}
- 340B Program funds

2. How Can FQHCs Support the National Diabetes Prevention Program?

FQHCs can be effective providers of National Diabetes Prevention Program (National DPP) lifestyle change program services given their strong focus on primary, preventive, and public health education services as well as their attention to patient engagement and “whole person care,” including addressing the social determinants of health.

FQHCs are important safety net providers and most FQHCs are [Medicaid-enrolled providers](#). That said, FQHCs are reimbursed differently than traditional Medicaid providers. Rather than being paid a fee for each service provided, FQHCs receive a single, bundled rate for each qualifying Medicaid visit. This single rate, known as a “PPS rate,” is calculated on a per-visit (or encounter) basis and is designed to cover all qualifying services and supplies provided during the visit. This is an important consideration when including FQHCs as a Medicaid-enrolled provider type for the National DPP lifestyle change program.

3. What is the FQHC Medicaid PPS Rate?

How does the FQHC Medicaid PPS work?

Medicaid reimburses FQHCs through an encounter-based prospective payment system (PPS) for the state Medicaid-covered services FQHCs provide (i.e., services that are included in the [Medicaid State Plan](#)).^{vii} Rather than being paid a fee for each service provided, FQHCs receive a single, bundled rate for each qualifying Medicaid visit. This single rate, known as a “PPS rate,” is calculated on a per-visit (or encounter) basis and is designed to cover all qualifying services and supplies provided during the visit.^{viii} The state pays the Medicaid PPS rates, which are matched with the state’s Federal Medical Assistance Percentage (FMAP).

States define which services are included in the PPS rate and establish limits on how many encounters an FQHC can bill per member per day. The PPS rate is a blended rate of all service costs (exclusive of costs or encounters for services paid separately from the PPS). States may also limit the number of reimbursable encounters in a year or require prior authorization for visits that exceed the amount allowed.^{ix} A separate Medicaid PPS is determined for each FQHC, calculated on a per-visit basis equal to the reasonable cost of services included in the rate.^x

When and why was the FQHC Medicaid PPS created?

The FQHC Medicaid PPS was created to ensure predictable and stable Medicaid reimbursement while protecting other federal investments that support operations and care provided to the uninsured (i.e., HRSA grant funds).^{xi} PPS rates were first calculated for FQHCs in 2001, derived from the historical costs of providing comprehensive care to Medicaid patients. The base rate was composed of the allowable capital cost per visit and the lesser of the allowable operating cost per visit or the peer group operating cost ceiling per visit. Payment rates for FQHCs that qualified for Medicaid payments after FY 2001 are based on either the average of other clinics in the same or adjacent areas or through cost reporting.^{xii}

How are FQHC Medicaid PPS rates updated over time?

Rates are adjusted annually to address inflation and changes in the scope of services provided. States use the Medicare Economic Index (MEI), a measure of medical practice cost inflation, to adjust payment rates. States are also required to adjust FQHC payment rates for each clinic to reflect changes in the scope of services included in PPS rates.^{xiii} A state could adjust an FQHC's PPS rate if an FQHC increased its capacity, either by improving facilities, building additional facilities, or providing other Medicaid-eligible services that were not covered or provided when the base rate was determined. The National Association of Community Health Centers (NACHC) purports that PPS rates have not kept pace with inflation or with changes to the range of services FQHCs provide. On average, PPS covers 80% of FQHCs' costs of caring for Medicaid patients.^{xiv}

How do FQHC Medicaid PPS rates differ across states?

States control a variety of factors that impact PPS rates, including:

- Defining which services are included in the encounter.
- Establishing limits on how many, and the types of encounters an FQHC can bill per member per day.^{xv}
- Limiting the number of reimbursable encounters in a year.
- Requiring prior authorization for encounters that exceed the number allowed.

What are the roles of HRSA, Medicaid, and FQHCs in setting the FQHC Medicaid PPS?

HRSA provides regulatory guidance for FQHCs and issues grants covering FQHC services provided to the uninsured, underinsured, and medically underserved areas.

Medicaid sets and pays PPS rates to cover any medical and any other ambulatory services provided to Medicaid enrollees by FQHCs and that are included in the Medicaid State Plan.^{xvi}

FQHCs provide medical and related services, provide data to justify rates, and receive payment by submitting claims to the state or managed care organization (MCO).^{xvii}

What other types of health centers operate under Medicaid encounter-based reimbursement systems?

Health centers are comprehensive, community-based primary care providers that offer affordable care in high-need areas and to high-need populations. Several types of health centers utilize a Medicaid encounter-based reimbursement system in addition to FQHCs, including rural health clinics (RHCs), Indian Health Services (IHS), and some tribal health clinics.

- ***Federally Qualified Health Centers***

FQHCs come in a variety of forms, including community health centers, migrant health centers, health care for the homeless health centers, and public housing primary care centers. As noted below, some outpatient health programs and health facilities operated by a tribe or tribal organization or by an Urban Indian Organization can also become FQHCs (although not all outpatient health programs and facilities operated by a tribe or tribal organization, or by Urban Indian Organizations are FQHCs). See U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services' (CMS) [Federally Qualified Health Center](#) and Grandfathered Tribal FQHC [Overview of Requirements and Policies](#) documents for more information.

There are also health center program “look-alikes.” FQHC look-alikes are primary care providers that meet the same requirements of the Health Center Program, but do not receive Health Center Program funding. However, they can apply to CMS for reimbursement under FQHC payment methodologies. Look-alikes are also eligible to receive automatic Health Professional Shortage Area designation, among other program benefits.

- ***Rural Health Clinics***

A RHC is a clinic located in a rural area (or non-urbanized area as defined by the U.S. Census Bureau) that is also a designated shortage or underserved area.^{xviii} Medicaid reimburses RHCs utilizing the same PPS methodology used with FQHCs (including the process for MCO supplemental payments). For more information on RHCs see Title XVIII 1861(aa)(1) and (2).

- ***Indian Health Services and Tribal Health Clinics***

IHS delivers health care to American Indians and Alaska Natives (AI/ANs). The IHS provides a health service delivery system for approximately 2.2 million American Indians and Alaska Natives, about 70% of whom live in urban areas. Funding for tribal and urban Indian health programs comes from IHS. Facilities include Indian Health Service Facilities, tribally operated 638 health centers, and Urban Indian Health Organizations.

Medicaid pays IHS facility providers applicable Office of Management and Budget (OMB) encounter-based rates, which are published annually in the Federal Register by IHS. Even though the IHS encounter-based rate and the FQHC PPS rate are both all-inclusive, they cover different services at different rates.

Tribal facilities can also be reimbursed in different ways.^{xix} Outpatient health programs, or facilities operated by a tribe or tribal organization under the Indian Self-Determination Act (i.e., tribally operated 638 health centers), and Urban Indian Organizations (which receive funds under Title V of the Indian Health Care Improvement Act), can become FQHCs by meeting program requirements and applying to HRSA for grant funding or look-alike status. See [HRSA Tribal &](#)

[Urban Indian Health Centers](#) for more information. Such FQHCs and look-alikes (sometimes known as Urban Indian Health Centers) receive Medicaid reimbursement under the PPS or other state-approved alternative payment methodology.

4. Can Services be Paid for Separately from the PPS Rate?

What services are not reimbursed via the PPS rate?

Some Medicaid-covered services are not reimbursed via the PPS rate.^{xx} Any costs associated with these services must be excluded from the FQHC Medicaid cost report (a form on which FQHCs report the cost and utilization information necessary for the PPS rate, submitted to state Medicaid agencies for reimbursement) or listed as a service that does not produce a billable encounter. Costs for these services are generally submitted for reimbursement on a separate claim using a different billing number and may require a different National Provider Identifier (NPI).

Some FQHCs use a different methodology to pay for services not included in the PPS rate. Delaware uses the PPS methodology for primary care costs, a cost-based methodology for administrative costs, and the actual acquisition costs for long-acting reversible contraceptives.^{xxi}

What is an FQHC Alternative Payment Methodology (APM)?

Under federal law, states can design and implement a different reimbursement model for their FQHCs, also known as an FQHC alternative payment methodology (FQHC APM). Implementing an APM requires a [state plan amendment \(SPA\)](#), agreement from the FQHCs affected by the FQHC APM to the change, and that the total FQHC APM payment be no less than what the FQHC would have received under the PPS. If total payments under the FQHC APM are less than what would have been paid under the PPS rate, the state must pay the difference to the FQHC.^{xxii}

As of 2020, 27 states use an FQHC APM to reimburse FQHCs for services to Medicaid patients. The most common APMs among states include using either a cost-based methodology (similar to what was used before the PPS) or a modified version of the PPS that calculates a new base rate by using different base years or an updated formula. The frequency of FQHC payments varies under FQHC APMs based on the specific methodology.^{xxiii} Some states pay FQHCs per visit, while others pay monthly or quarterly.

For more information on FQHC APMs see NACHC's [Snapshot: The FQHC Alternative Payment Methodology](#). Additional information on FQHC [Payment and Delivery Reform](#) is also available on the NACHC website.

5. How Would the National DPP Lifestyle Change Program Services be Reimbursed Through the PPS?

National DPP lifestyle change program services would either be included in an FQHC's PPS rate (possibly necessitating a scope of service change over time depending on the extent of services being provided) or be reimbursed separately (i.e., FQHCs would bill the Medicaid agency under a different billing number).

See the [Engaging Federally Qualified Health Centers](#) page of the Coverage Toolkit for state examples.

6. How Do Medicaid MCOs Reimburse FQHCs?

MCOs have broad flexibility in how they pay FQHCs for Medicaid-covered services and are not required to use FQHC Medicaid PPS rates. For example, MCOs can pay FQHCs a negotiated rate for being part of their network of providers and can incorporate FQHCs into value-based payment arrangements, including financial risk and shared savings related to meeting quality, outcome, and cost measures (e.g., diabetes prevention or management).^{xxiv}

However, this payment flexibility may cause some FQHCs to receive less compensation from MCOs than they would under the state's PPS rates. Under federal law, FQHCs that participate in managed care networks must eventually receive a payment that is at least equal to what the state would have paid under the PPS (in aggregate).^{xxv} When total MCO payments to an FQHC are less than what the MCO would have been paid under the PPS, the state must make periodic supplemental payments to the FQHC for the difference between the amount paid by the MCO and the amount to which the clinic is entitled under the PPS. Some states require that plans make full PPS payments to FQHCs to avoid supplemental payments. Reconciliation of supplemental payments generally occurs quarterly but must be made at least every four months.

7. How Do FQHCs Bill for *Medicare* Diabetes Prevention Program (MDPP) Services?

In general, FQHCs bill Medicare using the Medicare FQHC [Prospective Payment System \(PPS\)](#), which is different than FQHC's Medicaid PPS rates. Unlike Medicaid, there is not a process for adding additional services under the Medicare FQHC PPS. Since MDPP is not an FQHC PPS designated service, it is therefore not included in the Medicare FQHC PPS base payment rate.^{xxvi}

To be reimbursed for MDPP services, FQHCs must enroll as an MDPP supplier and ensure no commingling of FQHC resources used to furnish MDPP services by excluding all costs related to MDPP services from its Medicare FQHC PPS cost report.^{xxvii} Instead, FQHCs submit claims for MDPP services under a separate MDPP supplier agreement.^{xxviii} FQHCs use the CMS-1500 paper claim form or its electronic equivalent to bill for MDPP services under their MDPP supplier NPI. For more information, see [Medicare Diabetes Prevention Program \(MDPP\) Basics](#) page of the Coverage Toolkit.

Where Can I Find More Information?

National Association of Community Health Centers (NACHC)

NACHC is the national organization that supports community-based health centers. They promote the expansion of health care access for the medically underserved and uninsured, conduct research and analysis, provide training, leadership development, and technical assistance to community health centers, and help develop alliances and partnerships.

State Associations

Primary Care Associations (PCAs) are state or regional nonprofit organizations that provide training and technical assistance to FQHCs as well as other health centers and safety net providers. PCAs receive federal program support to develop and enhance services for their members. More information on PCAs and a map with links to each state's PCA is available on the [HRSA Health Center Program](#) website.

Individual FQHC/Community Health Centers

Each FQHC/health center operates as an independent private or public non-profit organization. Some health centers operate multiple clinics. A state PCA website may have the location and contact information for FQHCs/health centers operating within the state.

*Note that much of the information included in this document come from a
December 2017 MACPAC Issue Brief, available from:*

<https://www.macpac.gov/wp-content/uploads/2017/12/Medicaid-Payment-Policy-for-Federally-Qualified-Health-Centers.pdf>

Endnotes

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- ^{xviii} Rural Health Information Hub. Rural health Clinics (RHCs). Location Requirements. <https://www.ruralhealthinfo.org/topics/rural-health-clinics#location-requirements>
- ^{xix} For examples of four different options, see the [Michigan State Plan Amendment 20-0002](#).
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