The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) replaced the traditional cost-based reimbursement system for federally qualified health centers (FQHCs) with a new prospective payment system (PPS). The PPS reestablishes the Federal requirement that FQHCs be reimbursed at a minimum rate for services provided to Medicaid patients. This payment baseline is not nationwide but rather is based on the average of each FQHC’s FY1999 and FY2000 reasonable costs per visit rates -therefore, it is a unique payment rate for each FQHC. For existing FQHCs, a baseline per visit rate was established for services provided between January 1, 2001 and September 30, 2001, and then adjusted to take into account any change in the scope of services during that year. For FY2002 and the years thereafter, the per visit rate equals the previous year’s per visit rate, adjusted by the Medicare Economic Index (MEI) for primary care and any change in the FQHC’s scope of services.

BIPA establishes a minimum Medicaid per visit payment rate to which an FQHC is entitled. States may, however, choose to implement an alternative payment methodology (APM), including continuation of reasonable cost reimbursement, as long as the APM does not pay less than what FQHCs would have received under PPS and the affected FQHCs agree to it.

This checklist is part of a series of PPS best practice reports. It is a tool designed to help FQHCs and PCAs assess their current PPS rates. The laws which govern PPS are also addressed in Emerging Issues in the FQHC Prospective Payment System, State Policy Report #38.

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1 Public Law No. 106-554.
The initial/base year rate matters because the rates for “succeeding fiscal years” are based in part on the initial/base year’s rate. Mistakes or limits in the base year can continue to have an impact in later years.

Review information on how State set initial PPS rate.

- Does State maintain such information
- Was it provided to FQHCs
- Was rate development process explained to FQHCs

Does State employ any cost limits, caps, ceilings, screens or other cost limiting devices that effectively deny reimbursement for costs that are reasonable and related to furnishing covered ambulatory services – e.g.,:

- Cap on administrative costs or other cost categories
- Cap based on other centers’ rates (i.e., as a statewide average or use of “peer groups”)
- Limits on number of visits (i.e., 10 behavioral health visits per year or 24 FQHC visits per year)
- Limits that alter the definition of an encounter (i.e., a visit that requires additional physician supervision)

Does State adopt Medicare rates and methodology as its Medicaid PPS rate with or without making adjustments for Medicaid’s different set of services. For example:

- Provider productivity screens (4200 for physicians)
- Lower of actual rate or Medicare cap (Medicare has separate caps for urban and rural centers)
- Not paying on a per-visit reasonable cost basis appropriately for services not covered under Medicare such as dental

Does State include “FQHC services” and “any other ambulatory services” included in the State Plan or does it carve out certain services (ex., dental, podiatry, optometry)

- Who is a billable provider? Which provider can generate a face to face visit? (the definition of billable provider varies between the states but typically includes physicians, physician assistants, nurse practitioners, nurse midwives, visiting nurses, clinical psychologists, or licensed clinical social workers)
- Paying for some services under the per visit rate and paying for some at a lower rate or fee-for-service ("carving out" services from the PPS rate)
  - (common examples are dental and behavioral health services)
  - Inclusion of inpatient services performed in a hospital (i.e. deliveries)

**Does the State** use other grants (other revenue streams) to offset from allowable costs contrary to Medicare reimbursement methodology

<table>
<thead>
<tr>
<th>Setting of PPS Rates for New Starts</th>
<th>Section 1902(bb)(4)</th>
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<td>Consider all issues with respect to setting initial/base year rates set forth above</td>
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<tr>
<td><strong>Does the State</strong> establish a methodology for determining the average costs of other FQHCs in the same or adjacent area with a similar case load, for purposes of the interim rate as required by statute if the State chooses that option</td>
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<tr>
<td><strong>Does the State</strong> clearly and logically define “same or adjacent area” or “similar case load” or use a definition that is arbitrary</td>
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<tr>
<td><strong>Does the State</strong> provide reconciliation of cost-based rate for a “new start” FQHC to cover a prior period when the FQHC was paid under an interim rate</td>
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<th>Authorized Adjustment to PPS Rates: MEI</th>
<th>Section 1902(bb)(3)</th>
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<td><strong>Does State</strong> update the center’s PPS rate by applying the correct MEI factor to the corresponding time period</td>
<td></td>
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<tr>
<td><strong>Does State</strong> reconcile the center’s rate if a provisional inflation factor is used until the correct MEI is published</td>
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<tr>
<th>Authorized Adjustment to PPS Rates: Change in Scope</th>
<th>Section 1902(bb)(3)</th>
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<tr>
<td><strong>Does State</strong> establish any change in scope process or policy as required by the statute including:</td>
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<td>- Definition of qualifying /triggering events or using a partial definition (such as including the “type” of change but nothing as to changes in the intensity, duration or amount of service)</td>
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<tr>
<td>- Process for establishing the amount of adjustment</td>
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<td>- Requiring a minimum threshold of change (ex., 5% change) before the change in</td>
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scope can be made process to request an adjustment

- Is the change of scope rate adjustment methodology and policy reflected in Medicaid State Plan, as opposed to informal policy guidance

- **Does the State have** a process to account for many years of changes or actually accounting for many years of changes

- **Does the State** accept only changes that are of a time-limited nature or within a particular time period from their effective date
  - Example: an adjustment accounting for a change in scope expires after a certain time period (adjustment to account for adoption of EHR expires after a certain amount of time due to the expectation that inefficiencies resulting from adoption of EHR become minimized over time); change in scope may be submitted only one year from its effective date.

- **Does the State** accept only changes in scope that have been acknowledged by HRSA (e.g., where a center adds dental services to its 330 scope of project)

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### **Alternative Payment Methodology (“APM”) Related Issues**

<table>
<thead>
<tr>
<th><strong>Consider whether the APM Agreement</strong></th>
<th><strong>Section 1902(bb)(6)</strong></th>
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<tbody>
<tr>
<td><strong>APM Agreement affords centers sufficient protections:</strong></td>
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<tr>
<td>- Is the APM agreement in writing?</td>
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<td>- Does the agreement give the FQHC an opt out clause?</td>
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<tr>
<td>- Does the FQHC have the ability to withdraw its approval of the APM if it becomes problematic?</td>
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<tr>
<td>- Does the agreement specifically require a process for annual PPS comparison and notice of comparison rates and how they were calculated?</td>
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- **Does the APM** ensure that FQHCs are paid at least the PPS level annually
  - Keep PPS rates adjusted annually (to take into account both MEI and changes in scope) to be able to make this calculation

- If the APM = cost-based rate, evaluate all issues with respect to setting the initial/base rate identified above

- **Does the State** obtain individual FQHC agreement to the APM
Wraparound/Supplemental Payments and Other Managed Care Organization (“MCO”) Related Issues

Timing Issues

- **Should** make supplemental payments at least every 4 months
- **Should** timely reconcile payments in states that provide a provisional (or proxy) payment first

Calculation Issues

- **Does the State** offset other revenue from wraparound calculations such as
  - All MCO payments to the center, irrespective of what the payment was for (situation may arise when MCOs require FQHCs to enter into risk-based capitation contracts with the MCO under which the FQHC assumes risk for services beyond the scope of services the FQHC provides directly.) State then counts the total capitation payments paid by the MCO to the FQHC- including the amounts the FQHC is obligated to pay other providers under the risk-based contract - against the wraparound payment.
  - Offsetting incentive/bonus payments from the MCO to the center in making the wraparound calculation
- Does the State correctly convert capitated MCO payments to a per visit amount for the purposes of deducting what the MCO pays from the wraparound equation
- **Does the State** rely heavily on MCOs and/or fail to minimize MCO conflicts of interest (common red flag: high rate of MCO denials)
  - **Consider whether the State** refuses to provide wraparound on a claim unless the MCO pays first =“paid claim policy” (subjects FQHCs right to supplemental payments to MCO cost containment strategies such as credentialing and “timing out” of claims)
  - **Consider whether the State** delegates to MCOs the responsibility for paying the FQHC its full PPS (or APM) rate and, as a result, attempts to eliminate the state’s supplemental (wraparound) payment obligation

Process Issues

- **Consider whether the State** modifies its wraparound methodologies without amending the Medicaid State Plan, state regulation or otherwise providing public notice.

Urgent Care Services
**Does the State** ensure that either the State or the MCO pays FQHCs their PPS rate for urgent care services provided out-of-network to MCO enrollees (those enrollees who are enrolled in an MCO with which the FQHC does not have a provider agreement).

**Other**

*Provider Enrollment Requirements*

- **Does the State** require, as a precondition for enrollment as a Medicaid FQHC, Medicare site-specific certification.

- **Does the State’s** standard provider agreement purport to deny access to federal courts in the event of a dispute (ex., through use of a “forum selection” clause).

*Restrictions on Billable Encounters*

- **Does the State** require FQHCs to “bundle” multiple services into a single encounter (e.g., dental cleaning and dental exam) or refuse to pay for multiple services provided in separate encounters.
  
  Note: a change in a State’s bundling policy may trigger a change in a health center’s cost structure that may need to be taken into account through the PPS change in scope process

- **Does the State** implement “Four Walls” rules providing that billable encounters must be at the FQHC site (within its “four walls”) even though the services are included in the center’s Section 330 scope.

*Use of Third Party Liability Principles*

- **Evaluate whether the State** caps the Medicaid rate for FQHCs that serve dual eligible patients at the typically lower Medicare encounter rate.
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