



NATIONAL ASSOCIATION OF  
Community Health Centers

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# THE FQHC ALTERNATIVE PAYMENT METHODOLOGY TOOLKIT:

Fundamentals Of Developing  
A Capitated FQHC APM

*A Guide for Primary Care Associations and Health Centers*

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## ABOUT NACHC

Established in 1971, the National Association of Community Health Centers (NACHC) serves as the national voice for America's Health Centers and as an advocate for health care access for the medically underserved and uninsured.

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## NACHC'S MISSION

To promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved populations.

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# INTRODUCTION

## BACKGROUND ON HEALTH CENTER PAYMENT

Federally qualified health centers (FQHCs or “health centers”) are non-profit, community directed providers that serve as the primary medical home for over 25 million patients, including over 12 million Medicaid beneficiaries. In recognition of the critical role health centers play and the value that they deliver for Medicaid beneficiaries, Congress created a specific payment methodology for them, known as the FQHC Prospective Payment System (PPS). The FQHC PPS is different from traditional fee for service, as it is a comprehensive, bundled per visit payment. To provide increased flexibility, the law also allowed states to design and implement an alternative payment methodology (FQHC APM) so long as:

- ◇ The total FQHC APM reimbursement is not less than what the FQHC would have received with the FQHC PPS methodology
- ◇ Each affected FQHC individually agrees to the FQHC APM

This payment methodology is central to the successful relationship between health centers and Medicaid as, unlike other providers, health centers cannot and do not restrict how many Medicaid patients they care for if payment is too low. Therefore, adequate Medicaid payments are essential to health centers’ ability to continue providing comprehensive, high-quality care to their patients, regardless of their insurance status or ability to pay for services. Additionally, the FQHC PPS/APM ensures Federal 330 grant dollars are used as Congress intended—to care for patients without health insurance rather than subsidizing care for Medicaid patients.

As of 2017, over 20 states have chosen to use a FQHC APM to reimburse health centers for services provided

to Medicaid patients. The Medicaid FQHC APMs used by states commonly fall into five categories:

- ◇ **Full FQHC PPS via Managed Care:** In some states, the FQHCs are paid using the FQHC PPS methodology but the full rate is paid via the Medicaid managed care organization (MCO).
- ◇ **Reasonable Cost Per-Visit Bundled Payment:** Before the creation of the FQHC PPS/APM in 2001, health centers were reimbursed their reasonable costs associated with furnishing Medicaid covered services. Some states chose to continue using this methodology via an FQHC APM.
- ◇ **Rebased Per-Visit Bundled Payment:** Under this FQHC APM model, the State regularly rebases the health centers’ payment rates to reflect changes in services they provide and the cost of providing those services.
- ◇ **Per Member Per Month Bundled Payment:** These FQHC APMs delink payment from the face-to-face visit, converting the existing FQHC PPS/APM to a capitated per member per month (PMPM) payment. Health centers receiving payment under this methodology report that it allows for a more transformative use of the medical home, enabling them to maximize use of the care team and further meet the needs of their patients.
- ◇ **Bundled Payment with Quality Indicators:** While the majority are still under development, these emerging FQHC APMs (both per-visit and capitated PMPM models) provide incentives for meeting identified quality indicators while still ensuring total payments are not less than what health centers would have received under their FQHC PPS. Further work is needed to determine how best to incentivize addressing social risk as well as how to reward it.<sup>1</sup>

As health centers look to better align payment with practice, more and more are interested in utilizing the flexibility within federal Medicaid law to develop, in partnership with their state Primary Care Association (PCA) and Medicaid agency, FQHC APMs that provide reimbursement on a capitated PMPM basis. NACHC fully supports the development and testing of new FQHC APMs that seek to promote patient-centered, high-quality care while ensuring FQHCs are able to retain and sustain the defining features that have made the health center model successful. Therefore, NACHC has developed this toolkit to provide PCAs and health centers with knowledge and best practices for developing a capitated FQHC APM.

### **PURPOSE AND LIMITATIONS**

This FQHC APM toolkit is designed for state PCAs to use in developing FQHC APMs in collaboration with health centers in their states. The toolkit contains the most recent information the authors have at the time of publication. It should also be noted that this toolkit is informed by the experiences in various states, and that the Medicaid program varies from state to state, so any particular FQHC APM elements described here may not be applicable in your state. While this document was intended for use by PCAs, there are various aspects that could apply to individual health centers. However, each health center's experience, even in the same state, may vary within an FQHC APM.

Payment, policy and practice are interconnected. While the toolkit focuses primarily on the payment and policy structures that form an FQHC APM, health centers and PCAs will want to consider the systems and supports needed for the associated practice changes.

### **SOURCES**

This information comes from various sources around the country, and relies heavily on FQHC APMs already implemented in the states of Washington and Oregon, and under development in California and Colorado. As noted above, all of these models either include or envision a capitated per member per month (PMPM) payment. That is not to say that the capitated model is the only system compatible with practice transformation, or evolving payment reform systems in states, but rather that this is the predominant model currently in use. It should also be noted that these states (with the exception of Colorado) have a heavy penetration of Medicaid managed care, and all four expanded Medicaid under the Patient Protection and Affordable Care Act. The FQHC APM model can be used in non-expansion states, but the health centers and the PCA should evaluate the financial implications of practice transformation when Medicaid is a smaller portion of overall revenue.

## GOAL SETTING AND ENGAGEMENT FOR A FQHC APM

Developing a FQHC APM, like any big change that realigns the underpinnings of the current system, requires a substantial upfront investment in obtaining buy-in and understanding. Those who have implemented FQHC APMs, or are in the process of doing so, all echo this sentiment. For that reason, a PCA, along with its health center partners, should consider the following steps prior to beginning to develop a FQHC APM:

### 1. DEFINE THE HEALTH CENTER GOALS FOR A FQHC APM

Modifications in payment and policy may have implications for a health center's mission, operations and delivery model. Therefore, it is important that health centers take an active role in shaping payment and policy structures. In the context of a FQHC APM, that means defining the collective goals of the health centers. Here the PCA plays an essential role in facilitating transparent and open dialogue across health centers, taking input and refining the goals. Potential goals could include areas like improving:

- ◇ Quality and patient experience
- ◇ Patient access and care
- ◇ Financial sustainability
- ◇ Employee satisfaction

FQHC PPS/APM is a bundled payment, which allows for some flexibility in the services delivered during a patient visit. However, a health center may feel limited in how best to deliver care when paid on a per visit basis with eligible providers (as with FQHC PPS and some FQHC APMs). As noted above, one of the features of the

current wave of FQHC APMs is a capitated rate paid on a per member per month basis. Moving to a per patient payment may help meet many of these goals as providers at the health center have an increased ability to manage the health of their patient population with the support of the full care team. Another related goal may be moving away from visits as the way of defining provider and health center services. Given national trends and activities in certain states, the health centers may also see the pursuit of a more transformative FQHC APM as a proactive approach for helping to shape the Medicaid reforms in their state.

Under federal Medicaid law, a MCO must pay FQHCs no less than they would pay other providers for similar services. In some states, the state makes a supplemental payment (often referred to as a "wraparound payment") to the health center for the difference between the MCO payment and the FQHC PPS/APM rate. In other states, the MCO may pay a health center its full FQHC rate. In developing a FQHC APM, it is important to understand the importance of wraparound revenue to overall health center finances and cash flow. For example, Medicaid may constitute up to 60 percent of total revenue for some health centers. In addition, because managed care rates are traditionally lower than the FQHC PPS/APM rate, wraparound payments may be greater than managed care payments. Thus 30 percent or more of total health center revenue could come from the wraparound. Health centers may time the payment of the wraparound with their payroll. Therefore, the development of the new FQHC APM must consider both the overall health center budget as well as cash flow implications of changing the payment system, and preserving/improving cash flow may be a health center goal.

## 2. IDENTIFY STAKEHOLDERS AND THEIR GOALS

**HEALTH CENTERS:** As discussed above, health centers are the foundational stakeholder, both those who choose to participate in the FQHC APM and will see their payment change, as well as those who choose not to participate in the FQHC APM. While the FQHC APM is a financial vehicle, it is important to discuss the development of a new FQHC payment methodology with not only the health center Chief Financial Officers (CFOs) but also the Chief Executive Officers, Chief Medical Officers, Chief Information Officers and Boards of Directors to get a broader view of the health center goals.<sup>2</sup> As the process evolves, CFO engagement in this process is strongly encouraged to ensure health center finances remain stable under any proposal.

**HEALTH CENTER CONTROLLED NETWORKS:** The formation of health center controlled networks (“HCCNs” or “networks”) have enabled groups of health centers to collaborate, share, and/or integrate functions that are critical to health center operations (e.g., clinical, fiscal, information management, managed care, human resources, etc.). Through their collective efforts, health centers are often able to accomplish performance improvements that would have been cost prohibitive if attempted on their own. The network(s) in the state will provide valuable technical assistance related to the development, evaluation, and implementation of a FQHC APM.

**THE STATE:** One of the key factors identified by all of the PCAs who already have a capitated FQHC APM in place or under development is the health centers/PCA relationship with the State. Ideally, any FQHC APM will be developed jointly, in a partnership between the health centers/PCA and the State. This development will require a substantial amount of information sharing, and discussion of key FQHC APM elements. The PCA and the State may also find value in creating a

framework, including designated individuals, regularly scheduled meetings, review process, etc. The relationship with the State should also be monitored over time. For example, Oregon Primary Care Association (OPCA) staff reported that the engagement with the State over the FQHC APM improved their relationship over time.

The State may come into the FQHC APM discussion for a number of reasons. In some states, the State drove the discussion, in others, the FQHCs brought the idea to the State. Regardless of how the discussion begins, the State may have the following goals in developing a FQHC APM:

- ◆ **Reduction in total cost of care:** Many State Medicaid agencies are looking for ways to control overall spending. Thus the FQHC APM may fit into a larger context of payment/delivery system reform. While the FQHC APM may contribute to a larger reduction in total cost of care, reducing total cost of care should not be a direct, causal goal in the FQHC APM, because such results are difficult to demonstrate.
- ◆ **More predictable payment growth:** A capitated FQHC APM will remove the variability in payments that occur as a result of individual patients’ utilization.
- ◆ **Improvement in quality of care:** The FQHC APM may fit in well with other State efforts to improve quality of care for Medicaid patients.

Broadly, the goals of a capitated FQHC APM support the goals of the Triple Aim—to improve patient experience and population health while reducing system costs (**Figure 1**), which is a national focus as well.

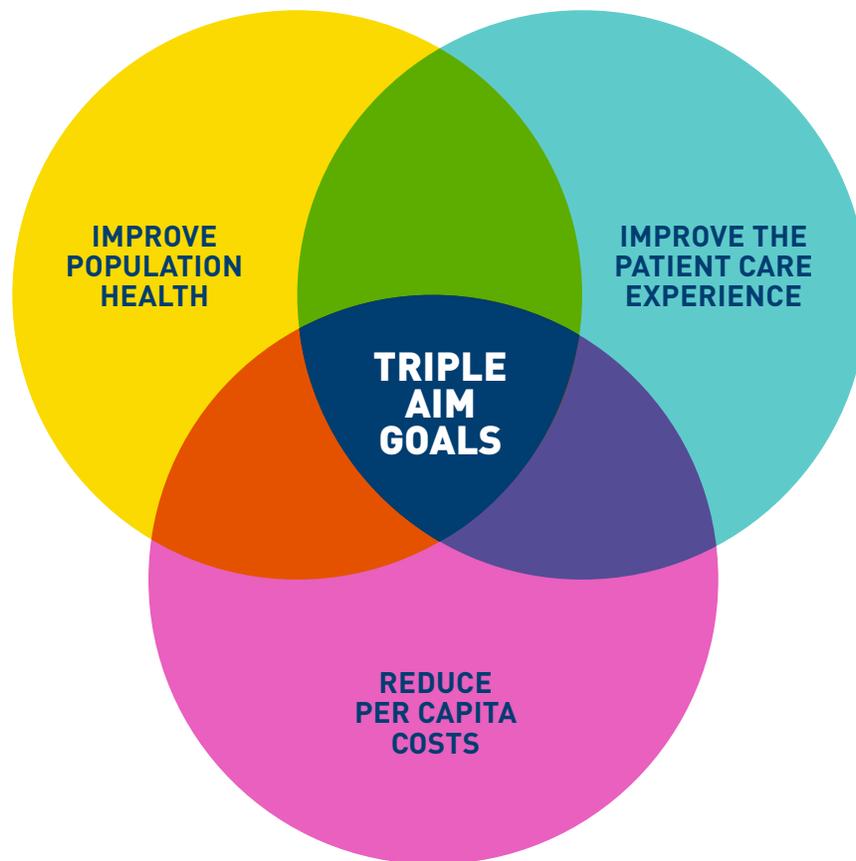
**Exhibit A** is the shared intent statement developed in Colorado between the health centers and the State.

In addition to health centers and the State Medicaid agency, stakeholders in the FQHC APM development and implementation efforts may include:

- ◆ **State Legislature:** While the state legislature may not be directly involved with the development process, they may need to pass legislation related to the FQHC APM.
- ◆ **State Budget Officials:** State budget officials may need to score the impact of the FQHC APM on the overall State budget, or approval of a specific budget item may be required.

- ◆ **Managed Care Organizations (MCOs):** MCOs may not be the drivers of the FQHC APM, but they may need to be active participants depending on the model and the state environment. There may not be specific MCO goals, but they do view both the State and the FQHC as essential partners. There may also be a different viewpoint between large, national for-profit MCOs, and local, non-profit MCOs. Also note that the FQHC APM could involve additional administrative work for the MCOs, without additional payment.

FIGURE  
1



*\*Institute for Healthcare Improvement (IHI)*

### 3. CREATE A VALUE STATEMENT AND BUSINESS CASE

In order to obtain buy-in and keep the FQHC APM development on track, it will be important to have a value statement and business case. The value statement will address the “why” of the FQHC APM, and needs to speak to more than just the mechanical changes. For the State, this value statement is likely to include delivery system reform and moving away from traditional payment methods. For health centers, the value statement is likely to include enabling practice transformation. In crafting the value statement, it is important not to inadvertently harm the current FQHC PPS /APM system(s), as some FQHCs may choose to remain with that current system. The business case will address how the system might look once the FQHC APM is in place. This would include highlighting specific benefits of the FQHC APM. The business case should also include a high-level illustration of how payment would change for an individual health center, such as how a health center is able to maintain stable Medicaid revenue with a full transition to a patient-centered medical home model, with less reliance on hard-to-recruit providers.

### 4. STATE PRIMARY CARE ASSOCIATION ROLE

State PCAs facilitate transparent and open dialogue across health centers, provide tailored training and technical assistance to health centers in their state(s), and maintain ongoing engagement with policymakers who establish and shape state Medicaid policy. These features contribute to the PCA’s key role in the development and implementation of a FQHC APM, especially in the early phases. In order to maintain a consistency of message, PCA staff should be the primary contact with the State. The PCA may also act to set up meetings or committee structures with the state. It is likely that there are a number of other ongoing initiatives in the state around practice transformation, care coordination,

and value-based payment. The PCA will take the role of ensuring that the FQHC APM is consistent with these activities.

The PCA plays an equally large role working with the health centers. The PCA should engage any consultants charged with developing the FQHC APM model (this may be in addition to consultants and actuaries retained by the State). In program development, the PCA should ensure that the needs of all of health centers are considered, and will set participation criteria as appropriate. Going into the FQHC APM, it is important that the PCA recognizes that some health centers may be fully satisfied with the existing FQHC PPS/APM methodology, and may want that methodology continued into the foreseeable future. The PCA may need to reconcile this viewpoint with the State’s desire not to run a pilot/reluctance to support two reimbursement systems.

Finally, the PCA plays a major role in education of both the State and of the health centers. PCA staff should research other models, and share that research with both parties. Since the health centers are geographically dispersed, PCA staff may need to go to individual health centers. For example, in California the PCA held multiple in person educational sessions across the state—first by the consultant retained by the PCA to help develop the program, and then by PCA staff to address the health centers’ concerns.

At the beginning of the process, the PCA should evaluate its resources, in terms of time and expertise, to support development of the FQHC APM. The full process is very time and resource intensive, and thus may require additional or dedicated staff. It may also include hiring a consultant or attorney, or other financial expenditures.

## RATE SETTING

The FQHC APM is, as its name implies, an alternative way of payment. Therefore, the FQHC APM requires a payment rate. If pursuing a capitated model, the payment rate is on a per-member basis each month (referred to as a “per member per month” or “PMPM” rate), mimicking the way that managed care companies are paid. Developing a FQHC APM that utilizes the PMPM rate setting methodology should include the following elements:

### BUDGET NEUTRALITY

The State may declare that their intention in a FQHC APM is not to pay FQHCs more than they are currently paying. One of the requirements of the FQHC APM under federal law is that the FQHC cannot receive less than they would have received under PPS. Therefore, a goal in developing the FQHC APM rate may be budget neutrality (i.e. that the FQHC gets paid the same amount that they would have under the existing PPS/APM). Since the FQHC will be paid on a different methodology, it is important to understand exactly what budget neutrality means. Budget neutrality could include the following elements:

- ◆ **Revenue neutral:** the FQHC APM uses current revenue to calculate the FQHC APM rate (see below).
- ◆ **Budget neutral on a per-patient basis:** the PMPM rate paid is the same implied PMPM rate as they are paid under the existing FQHC PPS/APM system.
- ◆ **Budget neutral on a per-visit basis:** while this is not necessarily the goal of the FQHC APM, if payments per visit are less than what the health center would have gotten under the existing payment methodology, the FQHC needs to be made whole to an equivalent amount through a reconciliation, in which case the resultant revenue per visit would be the same.

### RATE SPECIFICITY

A State Medicaid agency calculates an overall expense per patient for its planning processes. Medicaid MCOs are paid a PMPM premium by the State that may be dependent on aid category. However, each FQHC has its own PPS/APM rate, and in some states each site of the FQHC has its own rate. In addition, each FQHC has different Medicaid patient utilization (in terms of visits per Medicaid patient per year, or visits per Medicaid managed care member year). Therefore, it is essential that each FQHC has its own FQHC APM rate. Thus while FQHCs may receive the same MCO payment on a per unit basis, their wraparound revenue per visit will be very different.

### RATE SETTING PERIOD

As noted above, the most effective way to develop an FQHC APM is by using actual health center historical information. One of the key tasks will be to choose a time period from which this data is utilized. Considerations in choosing a time period should include factors that may create a different utilization/revenue profile in the new FQHC APM period vs. the data collection period:

- ◆ **Ensuring that 12 months of data can be used:** Health center patients and patient utilization may be seasonable or impacted by other factors such as changes in state policies or administrative procedures. Based on actuarial and other input, the State and the FQHCs may determine that a longer data reporting period may be appropriate.
- ◆ **Extraordinary events:** These could be such things as changes in Medicaid eligibility (such as Medicaid expansion), reduction in covered population, or removal of a Medicaid covered service such as adult dental or optometry.

- ◆ **Health center growth:** The state of development of a health center may impact the utilization rate per member per year. Either too new of a center may be an issue, or a health center that has added providers and access, thus increasing visits per member per year. In addition, a health center that experienced a large number of provider vacancies in a particular time period will have a depressed utilization rate.
- ◆ **A period far enough in the past that denied and pending claims have been resubmitted and resolved as appropriate:** This period should be at least six months long. For Medicaid managed care/ wraparound states, the period should also be late enough that any wraparound reconciliations have been completed and audited.
- ◆ **Data Integrity:** It is never appropriate to “scrub” or modify the data, and then use it in the calculation. This methodology could lead to a rate not consistent with actual experience. Moreover, it is important that the data used be trusted by the State and/or be the same data that the State is also using.

## COVERED SERVICES

FQHCs provide a broad range of separately identifiable services. For example, a health center may provide primary care, prenatal/postpartum care, dental, behavioral health, specialty mental health, optometry, podiatry, pharmacy, radiology, laboratory, as well as a broad range of specialty medical services. Some of these services are separately identifiable with different visits; others may be parts of visits. It is important that the FQHC APM be explicit about which, if any services, are carved out of the rate. For example, in Oregon, the following services were carved out of the FQHC APM:

- ◆ **Dental:** Dental was carved out at the request of the State. Dental services are easily identifiable using CDT codes.
- ◆ **Mental health:** Note that this service is specialty mental health, not behavioral health that is done in the primary care environment. In Oregon, there is a large range of the type and amount of mental health offered among the FQHCs, and thus developing a single capitated methodology was determined to be difficult (note that in Oregon the PCA and the State are investigating a methodology to add mental health to the capitated FQHC APM).
- ◆ **Obstetrics and Other Inpatient Services:** This service is highly variable from year to year at a health center; thus without sufficient volume, capitating it could lead to wide variations from year to year.

Covered services are also important when considering the FQHC APM change in scope. Even if a change in scope of services does not significantly impact a health center’s cost per visit, it is likely to have an impact on visits per member per month. There may be patients who only received carved-out services; these patients should be excluded from the member month calculation.

Another “carved out” service for PCAs and health centers to assess are prescription drugs. For example, health centers with a significant HIV population incur significant costs for medications provided to these patients. As new drugs come to market, the health center’s FQHC APM rate may not capture these steep increases.

## REVENUE

Revenue makes up the numerator of the FQHC APM's capitated PMPM rate. The revenue for the rate basis can be one of two streams:

- ◆ **Total Medicaid revenue in fee-for-service:** This approach would generally be used in states with no Medicaid managed care. This approach should be fairly straightforward, since the revenue in the health center's practice management system should match what is in the state's claim payment system. This revenue would probably also be used in states with Medicaid managed care where the managed care organization pays the health center its full FQHC payment rate.
- ◆ **Total Medicaid revenue in managed care (made up of two components):**
  - *Wraparound and reconciliation revenue:* This approach would generally be used in states with Medicaid managed care. The managed care companies pay the health centers negotiated rate, and the state makes the supplemental wraparound payment to the health center for the difference between the MCO payment and the FQHC PPS/APM rate. Thus, the revenue stream for the calculation would include any wraparound paid, be it on a capitated or fee for service basis, as well as any reconciliation amounts, either positive or negative.
  - *Medicaid managed care revenue:* Even though this amount will not be used in the calculation, it may be worthwhile to capture this information to validate that total Medicaid revenue is being used. Note that if this figure should change in the FQHC APM, especially on a PMPM basis, the reconciliation may be impacted.

Please note that this figure may not be the same amount as the FQHC's overall Medicaid revenue. There may be certain services that are not included in the FQHC PPS/APM rate, and those services would be billed/paid outside of the PPS/APM system, and thus should be excluded from the FQHC APM. This would include payments for outstationed eligibility workers, as well as out of scope services. Also note for states that are already using a FQHC APM, converting to a capitated FQHC APM would entail using current health center FQHC APM revenue for rate setting (not FQHC PPS-equivalent revenue).

## ATTRIBUTION

One of the key elements of the FQHC APM, and indeed one of the key issues facing health centers today, is attribution. Attribution is defined as the process of assigning patients to providers. There are several options for attributing patients to a health center:

- ◆ **Historical utilization:** The State has historical Medicaid utilization and can link this utilization via patient Medicaid identification numbers and FQHC provider numbers. Thus, a patient is attributed based on which provider they have seen.

While historical attribution may be a straightforward way to attribute patients, it brings in many considerations. Medicaid patients may receive services from multiple primary care providers. Some of these providers may be non-FQHCs, and some may be FQHCs not participating in the new FQHC APM. In Oregon, the PCA worked with the State to develop a rational patient assignment algorithm, which was a mathematical formula applied to the state claims database. This formula looked back 18 months, as it may be appropriate to develop a historical attribution greater than 12 months.

◆ **Managed care data set:** Most managed care companies assign patients to primary care providers. This assignment may be for purposes of paying capitation, or for giving the member a point of entry to the rest of the network. This attribution can come from three sources:

- *Managed care utilization:* Historical information from the claim payment system.
- *Patient/member choice:* Upon enrolling, new managed care members are usually given an opportunity to change their primary care provider. Patients may also be allowed to change primary care provider as frequently as monthly.
- *Auto-assignment:* When there is not historical data, and the patient has not chosen a primary care provider, the plan must auto-assign one. Auto-assignment is done based on an algorithm, and may include factors such as a patient's geography or a provider's panel size.

Health centers report that when they operate in a Medicaid managed care environment, they end up with a large number of patients assigned to them who they have never seen. They also report that the contact information for these patients is not always accurate, and therefore outreach to them is difficult. This is an important consideration in designing the FQHC APM, and for participating health centers. If the expected utilization per member per year is expected to increase because of outreach to these patients, a fixed PMPM rate may not appropriately compensate the health centers, and some sort of reconciliation protection needs to be built in. In addition, if the MCO attributes patients to the health center, but that attribution list is informal and not used to pay capitation, then the health center should reach out to the MCO in advance to rationalize the list before it is used in any FQHC APM calculations.

Historically-based member months are calculated reviewing a historical claims data set for a 12-month period. For calculation in a non-managed care environment or to calculate a FQHC APM rate for patients not included in the FQHC APM, the State Medicaid claims database should be used (which also relies on reporting from managed care organizations).

For calculation of a capitated FQHC APM, wraparound payments from the state claims database can be used. If it is possible to overlay this data set with Medicaid eligibility data, a more accurate number can be calculated, because while claims are paid only for Medicaid-enrolled patients, there may be gaps in coverage in between services. In other words, member months per member per year are not 12. In Oregon in the first year of the FQHC APM, the average member months per member per year were approximately 10.5 (this figure may rise under a Medicaid expansion). Individual health center analyses showed that approximately 60% of patients are enrolled in Medicaid for all 12 months in a year. Patient reassignment should also be used in this calculation (i.e. the member month count would stop for patients who utilized another primary care provider).

In the Oregon calculation of member months, the current procedural terminology (CPT) code was also utilized. Patients with a new patient evaluation and management code were determined to be new and the member month calculation started on that date. Patients with an established patient evaluation and management code were determined to have been attributed to the health center to the beginning of the 12-month period.

Member months in managed care are calculated from the MCO's data set. Ideally, the calculation should be based on each individual managed care member's Medicaid/plan enrollment, and the effective dates they were assigned/unassigned to the health center as their

primary care provider. This approach is superior to utilizing the monthly assignment list as patients may have been assigned/unassigned over the course of the month (or in some cases, retroactively).

If using MCO attribution, it is important to engage early in the process with the MCOs to ensure that their systems are aligned with the needs of the FQHC APM. This alignment could include:

- ◆ **Usable patient lists:** Both the State and the health centers participating in the FQHC APM will need to be able to get the member list in a usable electronic format (Note: PDF is not usable).
- ◆ **Differences between sites at an individual FQHC:** For states where there will be different FQHC APM rates for each health center site and/or all sites may not be included in the FQHC APM, it is important to determine if the managed care attribution is by site or by provider. While providers may work at multiple sites, the PPS/APM rate applies to only one site. In addition, patients may utilize services at multiple sites of the same FQHC. Therefore, the attribution rules, both in setting the rate as well as on an ongoing basis, need to be explicit on how these two situations are addressed.
- ◆ **Rule verification:** Ensure that attribution rules are consistent with the FQHC APM design.
- ◆ **HIT capabilities:** Establishing an attribution methodology must take into account who will identify patients for reassignment and how identification will take place. Information technology infrastructure will be needed to run such analyses. For example, the state or MCO will need to operationalize the attribution rules within their claims system.

An attribution list requires regular maintenance as it is updated every month. Therefore, the FQHC APM must include rules for patient reattribution. These rules should include provisions for patients who may lose and regain Medicaid coverage from month to month. It would also include patients who utilized other primary care providers, and thus are unassigned/reassigned. This information would come from the State's MMIS claim payment system (please note that given claims submission, payment, and reporting protocols, this data may take up to nine months to populate). In addition, since payments are based on assigned members, not visits, the State may desire to impose rules on engagement, for example, that any patient not seen within 18 months is removed from the attribution list.

In Oregon, the State created an attribution methodology with partial member months. That is, if a new patient came in for the first time on the 16th of a 30-day month, the patient would be counted for half the month. In rate setting, for that month the patient would be counted as a .5 member month. In the payment system, the participating health center would be paid half of their FQHC APM rate for that patient for that month.

## RATE CALCULATION

**Exhibit B** shows the rate calculation under two scenarios:

- ◆ **Scenario 1:** This scenario shows the rate calculation where either there is no Medicaid managed care, so all of the funds are paid by the State. In this case the health center performed 40,000 Medicaid visits over 12 months. Their FQHC PPS/APM per visit rate was \$150, so they were paid \$6,000,000 in total during those 12 months (note that the calculation will be the same if the payment comes from the State or the MCO). The health center had 13,000 Medicaid patients. However, not all patients were eligible for the

entire year, and so this equated to 135,500 member months, or an average of 10.5 member months per patient per year. Thus dividing the \$6,000,000 Medicaid revenue by the 136,500 member months calculates to a capitated FQHC APM rate of \$43.96 PMPM.

◆ **Scenario 2:** This second scenario shows the rate calculation where there is Medicaid managed care and the health center gets a payment from the MCO, and a supplemental wraparound payment from the State. In this case, the health center received \$2,500,000 in revenue from the Medicaid MCO, and \$3,500,000 from the State in wraparound revenue. Note that this \$3,500,000 could come from direct wraparound payments, or could come from a quarterly or annual reconciliation process. Also note that the ratio of payments, where the wraparound revenue exceeds the managed care revenue, is very common. The total revenue is the same at \$43.96 PMPM. The wraparound (and in this case the FQHC APM) portion of that revenue is \$25.64 PMPM, which will be the capitated FQHC APM rate.

One of the key elements of this calculation is that the rate setting methodology has the same criteria as the payment methodology. Therefore, rate setting needs to consider the following:

- ◆ Site (if there are different PPS rates for each site at a health center)
- ◆ Change in scope (see below)
- ◆ Medicaid Benefit Categories<sup>3</sup>

Developing rates by Medicaid benefit category presents several challenges related to data. While member/patient files with the State may be by the specific Medicaid program in which the patient is enrolled, very few health

centers have visits (the basis for revenue) by the state's beneficiary categories. This information may not be on either MCO or State Medicaid claims, and thus a two-part process would need to be developed, whereby members are first identified by aid code, and then the claim visit history is run on those members.

Since one of the federal rules on the FQHC APM is that each health center must individually agree to the rate, the FQHC APM should include a health center participation agreement. This agreement should include a provision where the health center is permitted to review the rate calculation and sign off on the rate before starting the FQHC APM.

### **MEDICAID CHANGE IN SCOPE**

Under federal Medicaid law, a health center's payment rate (whether FQHC PPS or APM) should be adjusted to take into account any increase or decrease of the type, intensity, duration and/or amount of services furnished by the health center. This process is called a "change in scope." Note that this change in scope is not the same thing as a 330 grant change in scope, although a 330 change of scope may be the driver of a Medicaid FQHC PPS/APM change in scope. A FQHC PPS/APM change in scope typically identifies a "triggering event" that complies with the definition of one of the elements of change. Depending on the state, changes in services can often be identified by a HRSA change in scope, with the accompanying Notice Of Award. Other changes may be dependent on state definitions.

Typically, a change in scope related to a health center's Medicaid payment rate includes the completion of a new cost report based on a health center's fiscal year. This cost report evaluates total cost divided by total billable visits, and the resulting cost per visit is the basis for the new rate. Note that even with a capitated FQHC APM, it will be necessary to maintain a FQHC PPS/APM per-visit rate, to pay for services and patients that fall outside of the capitated FQHC APM. A change in scope for a FQHC

APM brings in a new element, utilization (i.e. visits per member per year). Therefore, existing FQHC PPS/APM change in scope methodologies are insufficient for a capitated FQHC APM. A change in scope for a capitated FQHC APM needs to be developed whereby the participating health center can also demonstrate changes in utilization. The capitated FQHC APMs currently in use/under development have not yet finalized change in scope methodologies, so best practices could not be identified for this toolkit. However, the change in scope should delineate the following elements:

- ◇ What constitutes a change in scope? How does the health center document the change, including when there is not a corresponding HRSA change in scope?
- ◇ Are there thresholds by which the rate needs to change?
- ◇ Is a change in scope mandatory or optional for certain events?
- ◇ How does a health center demonstrate a change in utilization?
- ◇ What is the timing/sequencing for the change in scope? When does the new rate become effective?

The calculation of the new rate for the change in scope can take several forms. Three potential options, shown on **Exhibit C**, include:

- ◇ **Approach 1:** Change in FQHC APM rate based on change in default FQHC PPS/APM rate. In the first example, the health center completed a new cost report, showing that the new cost per visit is \$221.13. This represents a 10.0% increase from the old rate of \$201.00. In a non-managed care state,

the new FQHC APM rate would then increase by 10.0%. However, in a managed care state, since the FQHC APM is on the wraparound, this figure would not be correct. In this case, the amount of wraparound required to make the health center whole increased by 19.8%, from \$101.71 to \$121.84. Therefore, the FQHC APM rate should be increased by 19.8%, from \$32.91 PMPM, to \$39.07 PMPM.

- ◇ **Approach 2:** Change in FQHC APM rate based on costs and member months. This approach is essentially a rebasing of the FQHC APM rate, based on new data. In the example on **Exhibit C**, total costs in the FQHC APM year (this approach assumes the completion of a cost report) of \$7,788,099 were divided by the reported 123,270 member months to calculate a total cost PMPM of \$63.18. Managed care revenue was calculated at \$28.37 PMPM, and thus the new FQHC APM rate of \$34.81 PMPM is total cost minus managed care revenue.

- ◇ **Approach 3:** Change in FQHC APM rate based on incremental costs from change. In the example in **Exhibit C**, the health center had \$700,000 of incremental cost from the scope-changing item(s). Note that this level of detail is not contained in most cost reports, and thus a new cost report, or at least a new schedule, would need to be created. The incremental cost of \$700,000 is divided by the 123,270 member months. This incremental cost of \$5.68 PMPM is added to the existing rate, to yield a new FQHC APM rate of \$38.29 PMPM.

Note that all change in scope calculations should be inflated by Medicare Economic Index (MEI) or other agreed upon annual inflator to bring the rates into the current year.

## PAYMENT ELEMENTS

### CREATION OF ATTRIBUTION LIST

Since the FQHC APM rate is calculated on a monthly basis, FQHC APM payments are made on a monthly basis. A new, updated patient attribution list needs to be created every month. This list can be created from the prior month's list, adding or deleting patients as appropriate. Depending on the source of the data, the health center or the MCO, the list creation follows different criteria:

- ◆ **MCO source:** The MCO will only include its own patients on the FQHC APM list. Thus, this list will exclude patients who are no longer enrolled in Medicaid. If there is more than one Medicaid managed care MCO in the service area, these patients may shift to another MCO. In addition, the MCO's attribution list may include patients newly assigned to the health center; the health center may not yet have seen these patients. In a capitated FQHC APM, the MCO sends this list to both the State and the health center.
- ◆ **Health center source:** The health center would include any new patients seen in the last month. This list would be sent to the State, and the State would run edits to identify any patients no longer on Medicaid, or who had been attributed to another provider, would be removed.

In designing the FQHC APM, the PCA should request that the State include identification of additions and deletions on the monthly attributed patient list.

### FLOW OF DOLLARS

A capitated, per member per month rate is paid based on attributed members. The State would pay the health center, including any retroactive changes, on a prospective basis, usually within the first week of the month. These payments should be able to be made from the State's MMIS claim payment system through the current electronic funds routing system, but may

require a substantial amount of reprogramming. The full payment can also be made through the MCO. In this case it is preferable that the FQHC APM payment be separated from the regular managed care payment so that the health center can recognize any differences in MCO revenue.

### INTERNAL HEALTH CENTER RECONCILIATION

While not a requirement under the FQHC APM, each health center should reconcile the check that they receive from the State with any attached backup. They should also compare the list of assigned patients to any patients seen in the last month, in order to identify any missing patients. Health centers should establish a process with their State to address disputed and/or "missing" claims from the reconciliation. Health centers participating in a capitated FQHC APM report that they need to devote substantial resources to list management, especially at the start. In some cases, this has been a full-time job during the startup phase.

### PAYMENT RULES FOR SERVICES NOT INCLUDED IN THE FQHC APM

There will be a number of services that health centers provide that will not be covered by the FQHC APM rate (and thus not included in the calculation of the rate). These include services to patients newly enrolled in Medicaid who are not yet in a managed care plan, patients who are excluded from managed care (e.g. presumptive eligibility), and services that are reimbursable but not carved into the capitated FQHC APM. The PCA should work with the State to develop a comprehensive code set, including CPT and ICD codes, to identify FQHC APM-excluded services, and these codes should be programmed into the State MMIS so that Medicaid claims/wraparound would be paid for these FQHC APM-excluded services.

## MEDICAID PROCESS FOR IMPLEMENTING A FQHC APM

A Medicaid state plan is an agreement between a State and the Federal government describing how the State administers its Medicaid program. When planning to make a change to its Medicaid program, a State must send a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) for review and approval.<sup>4,5</sup>

As discussed earlier, Section 1902(bb) of the Social Security Act requires that each state Medicaid plan provide for payments for FQHC services in accordance with either use of the FQHC PPS methodology or an alternative payment methodology (FQHC APM).<sup>6</sup> Therefore, a State must secure approval of a SPA before implementation of a FQHC APM. The following describes the SPA process that health centers and PCAs can expect; however, a PCA should clarify the process details and timeline with the State.

**Under Section 1902 of the Social Security Act (SSA),** each state is required to have a state Medicaid plan reviewed and approved by CMS that describes the nature and scope of the State's Medicaid program (e.g., covered services, reimbursements to providers, eligibility requirements). States are required to administer their programs in accordance with the state Medicaid plan, but may seek to change administrative aspects of their programs through the use of a SPA.

### PUBLIC NOTICE

As part of the SPA process, the State is required to provide public notice of any significant proposed change in its methods and standards for setting payment rates.<sup>7</sup> The public notice must occur prior to the proposed effective date of the change. As implementing FQHC APM would be a change to the method for setting payment rates, it will require public notice in addition to the approval of a SPA. It is important to note that individual States may also have specific rules governing public notice and input.

### STATE PLAN AMENDMENT SUBMISSION PROCESS

Templates for state Medicaid plans and SPAs are provided by CMS. The submission process can be thought of as three major steps:

- ◆ **Governor Review:** The State Medicaid agency first submits its proposed SPA to the Governor (or the Governor's designee) for review and comment within a specific time period. Any comments from the Governor must be submitted to CMS along with the SPA.<sup>8</sup>
- ◆ **Conduct an access review, if necessary:** If a SPA proposes to restructure provider payments or reduce provider payment rates in a way that could result in diminished access to care, the State must also submit an access review for each service affected by the proposed SPA.<sup>9</sup> The access review must demonstrate that the state Medicaid plan will still comply with the access requirements of Section 1902(a)(30)(A) of the SSA. Prior to submitting the SPA to CMS, the State must consider input from beneficiaries, providers and affected stakeholders on the effect such changes to payment rates will have on access.<sup>10</sup> Along with the proposed SPA, the State must submit its analysis of the impact the change in payment rates will have on access.

◆ **Submit to CMS for review and approval:** If a SPA is required because of a change in federal Medicaid law, CMS will develop a preprinted template for States to complete for CMS' review and approval. If a SPA is needed because of a change at the state level, as with a new FQHC APM, the State will submit a CMS transmittal form along with the excerpted pages from the existing state Medicaid plan containing the proposed revisions. To simplify the process, a State can utilize CMS' state Medicaid plan "preprint" forms to check boxes indicating which options they have selected for their state plan's provisions.

### THE 90-DAY CLOCK AND EFFECTIVE DATE

CMS must send the State written notice to either disapprove a SPA or request further information within 90 days of receipt of the SPA in the regional office.<sup>11</sup> If CMS requests further information, the original 90-day clock is suspended and a new 90-day clock starts upon receipt of the information. If neither events occurs within the 90-day timeframe, the SPA will be considered approved and a notice of final determination is sent to the State.<sup>12</sup>

If approved, the effective date of a SPA depends on the type of amendment. Generally, the SPA, particularly to implement an FQHC APM, will become effective not earlier than the first day of the calendar quarter in which an approvable amendment is submitted to the regional office.<sup>13</sup>

With a few exceptions, any SPA that fulfills the federal Medicaid requirements must be approved by CMS.<sup>14</sup> CMS has indicated that it will review not only the SPA submission, but may also review any related or corresponding provisions of the state Medicaid plan which may lead to the identification of provisions that are contrary to federal Medicaid law.<sup>15</sup> In 2010 guidance,

however, CMS also informed that States will now have the option to resolve issues related to state plan provisions that are not integral to the SPA through a separate process.<sup>16</sup>

### REQUESTS FOR RECONSIDERATION

A State is permitted 60 days after receipt of notice of final determination to request that CMS reconsider its decision. The regulations also provide for an administrative hearing through which a final decision is made constituting a final agency action. If a State is still dissatisfied with the final agency action, it may pursue further appeals through the federal Circuit Court of Appeals and then the U.S. Supreme Court.<sup>17</sup>

## IMPLEMENTATION

### PARTICIPATION AGREEMENT

As previously noted, each FQHC must individually agree to the FQHC APM. They would do so via a participation agreement, which is a contract between the health center and the State. The participation agreement should include the following elements:

- ◆ **Term:** As with any contract, the length of the agreement needs to be specified. A year-long FQHC APM is probably not sufficient for either party. The reviewed FQHC APMs have 3-year participation agreements.
- ◆ **Termination:** This clause will be very important for the health centers, as they may have concerns that the FQHC APM, despite its design elements, could threaten their financial viability in several scenarios. Therefore, they would want an “out clause” to terminate their participation should such an event arise. The State may also want to retain the option to terminate non-performing health centers from participation in the FQHC APM.
- ◆ **Minimum participation requirements:** The State reserves the right to set minimum requirements, and the PCA and health centers may determine it prudent to define criteria for health center participation as well (see below for potential characteristics).
- ◆ **Accountability metrics:** In order to continue participation in the FQHC APM, the state may require that the health centers be held accountable for metrics related to quality, cost, or access. Careful thought should be given to any measurement design. As a capitated FQHC APM is intended to de-link payment from the defined visit, it is important not to replace the visit with another production model. The participation agreement will need to

define such metrics (if any), along with any further reporting requirements (see “Reporting” below for more information).

- ◆ **Rate calculation:** To describe the rate calculation methodology, and reaffirm that the health center reviews and signs off on the rate prior to agreeing to participate.
- ◆ **Attribution methodology:** While this section does not need to lay out the entire attribution algorithm, it should include the conditions by which patients are assigned to the health center and unassigned to the health center.
- ◆ **Included/excluded services**
- ◆ **Appeals process for reconciliation disputes and/or PMPM rate setting.**

### CHARACTERISTICS OF PARTICIPATING HEALTH CENTERS

In every state, health centers range in size, capabilities, and populations served. Therefore, it should not be the goal, at least initially, that every FQHC participate in the FQHC APM. In fact, the State may desire that the group of participating health centers be limited. Characteristics of health centers who are good candidates for the FQHC APM include (and note that the converse is true; health centers who do not have these characteristics are not good candidates):

- ◆ **Financial solvency:** This is best measured by days of cash on hand, and should be a minimum of 45 days. A higher threshold may be appropriate, but then consideration of other issues such as recent capital investments or large wraparound receivables should

be included, potentially by also looking at net assets. Another good indicator is positive operating cash flow.

◆ **In good standing:** Given that the FQHC APM represents a new partnership with the State, the current relationship must not be compromised by other potential issues. Thus any health center under investigation, or with a large amount of funds owed to the State, should not participate in the FQHC APM.

◆ **PCMH & Meaningful Use Certifications:** Both of these certifications represent a degree of internal capability in the health center. In addition, the ability to complete the steps required for certification are an illustration of the health center's wherewithal to take on new projects such as the FQHC APM.

◆ **Commitment to practice transformation:** The FQHC APM is not necessarily an end in itself, but more a means to an end. Thus, changing the payment system without changing the care delivery model does not meet the value proposition of the FQHC APM. This commitment can be shown by PCMH certification, workflow redesign, or hiring of new staff.

◆ **Reporting:** Participating in the FQHC APM will require the health center to develop a broad range of new internal and external reports. If the health center struggles to produce current reports, they may be unable to produce new reports. Ability to report current data is also a good proxy for a health center's data/information technology capabilities, which will be essential in the FQHC APM. Reporting is also a proxy for the health center's data collection capabilities; good data collection will be necessary in order to capture in order to capture other meaningful patient services (both interactions and support) provided outside of a traditional billable visit.

◆ **Established:** New FQHCs, or new sites of existing FQHCs, may not be good candidates for the FQHC APM because they have not yet built the full utilization pattern of the attributed patients. In addition, limited historical data may exist for the rate calculation.

◆ **Appropriate rate and historical reimbursement:** The data set used for rate setting for the FQHC APM should provide an appropriate input for rate setting/reimbursement under the FQHC APM. If a health center has an existing FQHC PPS/APM rate that does not appropriately reflect the services it provides, then it may not be appropriate for that health center to participate until better financial data exists.<sup>18</sup> If a health center is undergoing a FQHC PPS/APM change in scope, the incremental rate difference can be incorporated into the rate. If the health center had an adverse experience with revenue, because of a large settlement or the implementation of a new practice management or EHR system, their historical data may not be appropriate.

**For PCAs reviewing the policies related**

to the current FQHC PPS/APM to ensure rates appropriately reflects the services the health centers provide before developing a new FQHC APM, see [NACHC's Medicaid Prospective Payment System Checklist](#).

◆ **Willingness of MCO to participate:** In states where the attribution is done based on MCO lists, it is essential that the MCO commits to supply the necessary data. Some health centers may work with multiple MCOs, and so their cooperation/participating needs to be secured. Where managed care

contracts go through an Independent Practitioner Association (IPA), the managed care organization still needs to be the source of data.

- ◆ **Minimum size:** Smaller health centers present too much statistical variation, in addition to potentially not meeting some of the characteristics above, and thus may not be good candidates for participation.
- ◆ **Medicaid payor mix:** For many health centers, Medicaid constitutes half or more of their visits. However, there may be other centers, for example those in non-expansion states or homeless clinics, where Medicaid is less than 40% of the visits, may not be good candidates.

## FORM OF IMPLEMENTATION

As noted above, there may be health centers that choose not to participate in the FQHC APM, and there may be health centers who do not yet fulfill the necessary criteria. There may be another group of health centers that would like to participate in the FQHC APM, but would like to see how the FQHC APM functions first. And then there may be a group of health centers that enthusiastically embrace the FQHC APM. Recognizing that different health centers within the state are at different places with the FQHC APM, it may be appropriate to develop a pilot program. A pilot program is a voluntary, potentially limited program to test out the FQHC APM. While the pilot FQHC APM will be based on an initial set of rules and regulations, the State, the PCA, and the health centers will want to recognize that the program is open to change.

## DAY 1 OF THE FQHC APM

There are a number of systems that need to be in place to start the FQHC APM:

- ◆ **Day 1 list:** The initial list of attributed members may be the most difficult to produce. Note that the

Day 1 list is unlikely to be the same data set as the member months used for rate setting, since the rate setting information is historical, and the Day 1 list reflects current patients. For example, with the Oregon FQHC APM, the attribution methodology was different for the historical member month calculation (looked back 12 months) and the Day 1 list (looked back 18 months). Additionally, the State will only pay for currently enrolled members, so any Day 1 list needs to be run through an eligibility screen.

**To assist health centers** in determining their readiness to participate in a new FQHC APM, PCAs may want to utilize [NACHC's Payment Reform Readiness Assessment Tool](#).

- ◆ **System setup:** No State currently pays FQHCs on capitation prior to Day 1. Therefore, in order to pay a capitated wraparound rate, the State Medicaid claim system likely needs to be reprogrammed to pay capitation. This could be a lengthy process, and thus the programming needs to begin as soon as the specifications for the FQHC APM are developed. Additionally, this may be a costly process and part of the State's fiscal assessment of moving forward with a FQHC APM.
- ◆ **Health center reconciliation:** It is a misconception that moving to a FQHC APM will substantially reduce the work of an FQHC's billing department. The billing infrastructure will need to remain in place to bill other payors, and there will also still be work for Medicaid. The health center will need to reconcile the FQHC APM attribution list to its actual patient experience, given the size of the payment and the

portion of the health center’s total budget. Additionally, it is unlikely that all Medicaid-covered services will be carved into the capitated FQHC APM.

There are a number of changes in the implementation of a FQHC APM, and many elements that can impact the way and amount in which a health center is paid. Immediately after the first payment is made, the PCA should coordinate communication between the participating FQHC APM health centers and the State. This process should include soliciting feedback from every participating health center. The PCA should identify any potential program or technical changes required, and should also be able to address health center questions and concerns.

### ANNUAL INFLATION

Because the FQHC APM has a fixed payment rate, it is entirely appropriate to use an inflation update mechanism. Today, the Medicare Economic Index (MEI) is most commonly used among states to inflate FQHC Medicaid PPS/APM per-visit rates. Another annual inflator health centers and States may want to consider is the FQHC-specific market basket, which replaced MEI as the methodology for adjusting payment rates for the Medicare FQHC PPS. This FQHC-specific market basket was developed to more accurately reflect the services provided at a health center.

In the first year of the FQHC APM, depending on the implementation date, it may be necessary to use a partial year update. **Figure 2 below demonstrates a rate update using both mechanisms. See Exhibit B for example.**

FIGURE 2	MEI UPDATE	MARKET BASKET UPDATE
2016 RATE	\$43.69 PMPM	\$43.96 PMPM
2017 RATE	\$44.49 PMPM (1.2% increase)	\$44.75 PMPM (1.8% increase)

**For more information** on enabling services, see the Association of Asian Pacific Community Health Organizations’ [Enabling Services Accountability Project](#)

### REPORTING

Since FQHC APMs are so closely tied to practice transformation, it is appropriate that a component of the FQHC APM include reporting on practice transformation. This reporting could include the following elements:

◆ **Other Meaningful Patient Services:** One of the key components of the practice transformation enabled by a FQHC APM is delinking payment from a visit with a billable provider to services provided by other members of the care team and via modes that were not previously recognized, such as visits with a nutritionist or communicating with a patient via email or phone. There may not be a coding system for many of these services. Thus, if one of the requirements is to report on meaningful patient services and interactions, then a taxonomy of enabling services, with common definitions needs to be developed, since there is not currently a nationally accepted standard for these services. In addition, participating health centers need to determine how their practice management and electronic health record systems can capture these codes. Note that these services are generally not CPT-codable. A sample of the Oregon care steps report is shown on **Exhibit D**.

◆ **Access:** Patients will still need to have access to their primary care provider on a timely basis, regardless of how robust the support system is. Therefore, the FQHC APM could include reporting on appointment availability, in terms of next available

appointment or third next available appointment. The system could also include measuring access for newly attributed patients.

- ◆ **Quality:** Quality measures could be based on either Uniform Data System (UDS) measures, or on HEDIS measures, or a combination of both. In the initial development of the FQHC APM, it is best to use existing measures.

The reporting of these and other elements are important to assess the effectiveness of the new payment system or FQHC APM. PCAs and health centers should be cautioned not to enter into a FQHC APM that is tied to these measures and would put FQHCs at risk of having their total Medicaid reimbursements be less than what they would have received under the FQHC PPS, as is a core component of the statute allowing for a FQHC APM. Quality measurement efforts to date do not account for the social determinants of health nor do they recognize workforce challenges health centers face.

While total cost of care is an important goal, it is not information that the health center has and thus would not be a reporting element of the FQHC APM that is supplied by the MCO or the State. One should not underestimate the complexity of accessing this data in a timely manner. Additionally, as so many factors contributing to the total cost of care fall outside the health centers' control, they should not be held accountable for this.

## RECONCILIATION

In a FQHC APM, a reconciliation can serve at least two purposes: 1) ensuring that the FQHCs are paid at least what they would have been paid under the PPS per-visit methodology, and 2) for the State to track the level of services provided to Medicaid patients (since they will no longer be receiving claims volume directly through

claims payment). The reconciliation needs to be done on a regular basis (in the Oregon FQHC APM, the State had proposed an annual reconciliation. CMS' major change to the entire FQHC APM was to require that reconciliation be done on a quarterly basis). The reconciliation would include the following elements:

- ◆ **FQHC APM billable visits:** This includes even those not billed. This information resides in the health center's practice management/electronic health record system. The MCO may also require encounter reporting, and would require reporting of all activities that drive HEDIS measures. There may also be specific types of visits that would continue at current levels regardless of the level of practice transformation, such as prenatal visits, annual physicals, and initial visits for newly assigned managed care patients. Generally, it is better when this information is reported by the FQHC and subject to State audit, as reporting from the MOC may be subject to issues in the claims payment system.
- ◆ **FQHC PPS rate:** The FQHC will continue to need a FQHC rate to pay for FQHC services delivered outside of the new FQHC APM (for example, patients not yet assigned under the new FQHC APM attribution methodology). This rate would also be used for the rate multiplied by visits calculation of the FQHC PPS equivalent revenue.
- ◆ **Managed care revenue:** MCOs can continue to pay the FQHC using current methodologies. This payment can be either capitated or fee-for-service, even if the FQHC APM is capitated. This revenue should be recorded on an accrual basis, but the reconciliation should be far enough after the FQHC APM period that sufficient claim runout has occurred.

◆ **Wraparound payment revenue:** The State will easily be able to audit this figure, as the payor of the supplemental wraparound payment.

A sample reconciliation report is shown on **Exhibit E**. If managed care and wraparound revenue is less than visits times the rate, the FQHC did not get at least what they would have gotten under the PPS per visit methodology and the State will need to make the FQHC whole. If the revenue is more, the State may request that the funds are paid back (although in the Oregon and other emerging models, the States allow the health centers to keep these funds, as long as there is sufficient patient engagement, with the understanding that practice transformation will reduce the number of visits per patient per year). In this case, the Medicaid MCOs paid the health center \$2,500,680, and the State paid \$3,499,860 through the FQHC APM, for a total of \$6,000,540. The health center performed 39,000 Medicaid visits, and their FQHC PPS rate was \$150. Therefore, their PPS equivalent revenue was \$5,850,000. This figure is less than the \$6,000,540, and therefore the health center was paid at least what they would have been under PPS. In the Oregon model, the health center could keep the \$150,540 difference to reinvest in practice transformation and services not previously reimbursable.

## COLORADO'S SHARED INTENT FOR FQHC APM

*Approved by Board of Directors on December 7, 2016*

CCHN staff recommend the adoption of the below statement to help guide the development of a new Medicaid APM rate with the state Medicaid agency. This statement:

- ✓ Was reviewed by the Rates Workgroup in September.
- ✓ Was approved by the Payment Reform Committee in November after changes made to reflect discussion in October.
- ✓ Has been okayed in the below form by the state Medicaid agency.



The Colorado Department of Health Care Policy and Financing (HCPF) and Colorado Community Health Network (CCHN), representing Colorado's 20 Community Health Centers (CHC), share a commitment to high-quality care which results in improved patient and population health outcomes, improved patient and provider experience, and reduced total cost of care (e.g. the Quadruple Aim).

Based on this shared commitment, the intent of changing CHC Medicaid reimbursement away from volume and towards value is to provide CHCs with the flexibility they need to transform care to achieve the Quadruple Aim.

HCPF and CCHN recognize that these changes will alter the way care is delivered and change the mix of traditional encounters and other engagement services historically not billed to Medicaid. It is anticipated that overall engagement with patients will increase, though per patient number of traditional encounters may decrease. HCPF, CCHN and participating CHCs are committed to tracking success of the model based on agreed upon outcome metrics and increased access which is not strictly defined as traditional encounters.

In developing and implementing a pilot Alternative Payment and Care Model (APCM), we hold ourselves accountable to:

- ◇ A data driven process in which CHCs are responsible for reporting on access, quality and patient experience, supported by HCPF, CCHN, and CCMCN through data analytics to help drive innovation, collaborative learning and improvement.
- ◇ Fiscal balance which recognizes that the APCM cannot cost the state more than it would have otherwise, CHCs cannot be expected to transform care and increase services with reduced funding, and some savings in total cost of care should be reinvested in the responsible system to expand access.
- ◇ Flexibility to quickly recognize and address implementation issues through mutually acceptable solutions.
- ◇ Transparency regarding metrics and the impact the APCM is having on participating FQHC patient health outcomes and total Medicaid per-patient cost of care.

## EXAMPLE FQHC APM RATE CALCULATION

### SCENARIO 1: NO MANAGED CARE/FULL PAYMENT THROUGH MCO

CURRENT MEDICAID VISITS	40,000
CURRENT PPS RATE	\$150.00
CURRENT MEDICAID PPS REVENUE	\$6,000,000

MEDICAID PATIENTS	13,000
MEDICAID MEMBER MONTHS (10.5 PMPY)	136,500

APM RATE PMPM	\$43.96
MEDICARE ECONOMIC INDEX	1.2%
2016 PMPM RATE ADJUSTED FOR 2017	\$44.49

APM RATE PMPM	\$43.96
FQHC MARKET BASKET	1.8%
2016 PMPM RATE ADJUSTED FOR 2017	\$44.75

MONTHLY MEMBERSHIP	11,375
MONTHLY APM REVENUE	\$500,045

### SCENARIO 2: MANAGED CARE WITH WRAPAROUND

CURRENT MANAGED CARE REVENUE	\$2,500,000
CURRENT WRAPAROUND/RECONCILIATION REVENUE	\$3,500,000
CURRENT MEDICAID PPS REVENUE	\$6,000,000

MEDICAID MEMBER MONTHS	136,500
MEDICAID PATIENTS	13,000
AVERAGE MEMBER MONTHS PMPY	

TOTAL REVENUE PMPM	\$43.96
MANAGED CARE REVENUE PMPM	\$18.32

## EXAMPLE FQHC APM MEDICAID CHANGE IN SCOPE METHODOLOGIES

CURRENT APM PMPM RATE	\$32.61
CURRENT PPS RATE	\$201.00
CURRENT % OF MEDICAID REVENUE FROM WRAPAROUND	51%

TOTAL ALLOWABLE COST CURRENT APM YEAR	\$7,788,079
TOTAL VISITS CURRENT APM YEAR	35,220
NEW PPS RATE FROM CIS	\$221.13

### APPROACH 1: INCREMENTAL PPS

CURRENT WRAPAROUND REVENUE PER VISIT	\$101.71
CURRENT IMPLIED MANAGED CARE REVENUE PER VISIT	\$99.29
WRAPAROUND DIFFERENTIAL WITH NEW PPS RATE	\$121.84
% WRAPAROUND INCREASE	19.8%
NEW APM PMPM RATE	\$39.07

### APPROACH 2: RECALCULATED APM RATE

TOTAL ALLOWABLE COST CURRENT APM YEAR	\$7,788,079
TOTAL MEMBER MONTHS CURRENT APM YEAR	123,270
TOTAL COST PMPM	\$63.18
MANAGED CARE REVENUE PMPM	\$24.50
REVISED APM RATE	\$38.68

### APPROACH 3: INCREMENTAL APM RATE

INCREMENTAL COST FROM SCOPE CHANGE	\$700,000
INCREMENTAL COST PER MEMBER MONTH	\$5.68
REVISED APM RATE	\$38.29

## OREGON'S APCM CARE STEPS REPORT

### ENGAGEMENT TOUCHES



In the Alternative Payment and Advanced Care Model (APCM) program, collaboratively developed by the Oregon Health Authority, Oregon Primary Care Association and participating Oregon Federally Qualified Health Centers, patient access to health care is no longer defined only by the traditional face-to-face office visit.

The goal of the Care STEPs documentation system is to demonstrate the range of ways in which health center teams are providing access to services and value to patients. Care STEPs data are collected and submitted quarterly so that OHA can better understand the non-billable and non-visit-based care and services that are being delivered as the Patient-Centered Primary Care Home model advances under APCM.

A Care STEP is a specific direct interaction between the health center staff and the patient, the patient's family or authorized representative(s) through in-person, digital, group visits, or telephonic means. There are currently 18 Care STEPs, grouped into four categories: 1) New Visit Types, 2) Education, Wellness and Health Promotion, 3) Coordination and Integration, and 4) Reducing Barriers to Health the definitions are listed below.

The definitions and guidance on when to document each Care STEP is provided below. If more than one Care STEP is conducted during a single interaction with a patient, document all of the Care STEPs that correspond with the services provided to the patient. For example, a nurse is conducting gaps in care outreach to patients with diabetes who are due for an HbA1c test. The nurse initiates a telephone call with the patient and discusses the patient's gaps in care. The patient would like to come to the clinic to complete the lab test, but does not have the money for bus fare. The nurse helps to arrange transportation for the patient. During this call, the nurse asks the patient about their top concerns in managing their diabetes and the patient discloses sometimes running out of money to buy groceries. The nurse creates a referral for the patient to the local food pantry and creates a plan to follow up with the patient the following week to see if the patient was able to access the local food resource services. In this call, the nurse should document the completion of three Care STEPs: 1) Gaps in Care Outreach, 2) Transportation Assistance, and 3) Accessing Community Resource/Services.

#### NEW VISIT TYPES

- Online Portal Engagement
- Health and Wellness Call
- Home Visit (Billable Encounter)
- Home Visit (Non-Billable Encounter)
- Advanced Technology Interactions

#### COORDINATION AND INTEGRATION

- Coordinating Care: Clinical Follow Up and Transitions in care settings
- Coordinating Care: Dental
- Behavioral Health and Functional Ability Screenings
- Warm Hand-Off

#### EDUCATION, WELLNESS AND HEALTH PROMOTION

- Care Gap Outreach
- Education Provided in Group Setting
- Exercise Class Participant
- Support Group Participant
- Health Education Supportive Counseling

#### REDUCING BARRIERS TO HEALTH

- Social Determinants of Health Screening
- Case Management
- Accessing Community Resource/Service
- Transportation Assistance

## NEW VISIT TYPES

CARE STEP	DEFINITION	USE
<b>ONLINE PORTAL ENGAGEMENT</b>	Patient and/or family communicate with members of the care team using a web portal application within the electronic health record system that allows patients to connect directly with their provider and care team securely over the internet.	This Care STEP should be counted when a message is sent from the patient or the patient's care team sends a message to them.
<b>HEALTH AND WELLNESS CALL</b>	Health center provider or qualified health professional <sup>20</sup> speaks to the patient or family/representative over the telephone about health and/or wellness status to discuss or create care plan, treatment options, and/or health promotion activities (with the exception of tobacco cessation or maternity case management <sup>1</sup> )	This Care STEP should be counted when health center staff member speaks with patient or family/representative about health and/or wellness status AND discusses or creates care plan OR discusses treatment options OR discusses health promotion activities. Standard clinical operations such as appointment reminders and calls supporting other administrative processes should not be recorded.
<b>HOME VISIT (NON-BILLABLE)</b>	Health center staff visit the patient's home for reasons unrelated to assessment, diagnosis, treatment, or Maternity Case Management.  Non-billable home visits include but are not limited to:  A community health worker visiting patient's residence to support the family or a clinical pharmacist visiting to assist with medication management and reconciliation.	This Care STEP should be counted upon completion of the home visit as defined in the definition section.
<b>HOME VISIT ENCOUNTER</b>	Health center staff conduct a billable home visit. The Division considers a home visit for assessment, diagnosis, treatment or Maternity Case Management as an encounter <sup>2</sup> .	This Care STEP should be counted when a health center provider or other qualified health professional conducts a billable home visit at a patient's residence or facility for assessment, diagnosis, treatment, or Maternity Case Management.

## NEW VISIT TYPES

CARE STEP	DEFINITION	USE
<p><b>ADVANCED TECHNOLOGY INTERACTIONS</b></p>	<p>This Care STEP includes telemedicine encounters, as well as other types of interactions supported by technologies not historically used for providing health care, such as text messaging or the use of smartphone applications for remote patient monitoring or other health promotion activities.</p>	<p>This Care STEP should be counted when:</p> <ol style="list-style-type: none"> <li>1. Patient consultations using videoconferencing, a synchronous (live two-way interactive) video transmission resulting in real time communication between a medical practitioner located in a distant site and the client being evaluated and located in an originating site that is a billable telemedicine encounter according to OAR<sup>3</sup> are conducted OR when a non-billable interaction between a member of the health care team and the patient using videoconferencing takes place.</li> <li>2. Health center staff uses a non-traditional technology, such as text messaging or smartphone application, to interact with patients regarding their health and wellness status OR discuss their care plan or treatment options OR provide health promotion based on the patient's health status or risk factors. Outreach efforts where the patient does not reply may not be counted.</li> </ol>

## EDUCATION, WELLNESS AND HEALTH PROMOTION

CARE STEP	DEFINITION	USE
<b>CARE GAP OUTREACH</b>	Health center staff identify gaps in care for their empaneled patients and speak with patients or family/representative to help them access the appropriate health promotion, preventive or chronic disease management care and services.	This Care STEP should be counted when health center staff have spoken in-person or over the phone with patient or family/representative regarding gaps in care.
<b>EDUCATION PROVIDED IN GROUP SETTING</b>	Patient attends an education group related to health promotion activities (such as parenting/pregnancy classes, health fairs, and teaching kitchens/healthy cooking classes) provided by health center staff or affiliated group. <sup>4</sup>	This Care STEP should be counted when the health center verifies that the individual patient attended the education class/event provided by the health center or affiliated group. Verification may come from the patient.
<b>EXERCISE CLASS PARTICIPANT</b>	Patient attends an exercise class (such as a low-impact walking group, yoga, Zumba, or Tai Chi) provided by the health center or affiliated group. <sup>4</sup>	This Care STEP should be counted when the health center verifies that the individual patient attended the exercise class/event provided by the health center or affiliated group. Verification may come from the patient.
<b>SUPPORT GROUP PARTICIPANT</b>	The patient attends a support group for people with common experiences and concerns, who provide emotional and moral support for one another, hosted by the health center or affiliated group. <sup>4</sup>	This Care STEP should be counted when health center staff have verified patient attended a support group hosted by their health center or referred to by the health center. Verification may come from the patient.
<b>HEALTH EDUCATION SUPPORTIVE COUNSELING</b>	Services provided by a physician or other qualified health care professional <sup>5</sup> to an individual or family, in which wellness, preventive disease management, or other improved health outcomes are attempted through discussion with patient or family. Wellness or preventive disease management counseling will vary with age and risk factors and may address such issues as family problems, social circumstances, diet and exercise, substance use, sexual practices, injury prevention, dental health, and diagnostic and laboratory test results available at the time of the encounter.	This Care STEP should be counted when health center staff engages in the activities described in the definition.

## COORDINATION AND INTEGRATION

CARE STEP	DEFINITION	USE
<b>COORDINATING CARE: CLINICAL FOLLOW-UP AND TRANSITIONS IN CARE SETTING</b>	<p>Health center staff speaks with patient or family/representative regarding the patient’s recent care at an outside health organization (ER, hospital, long-term care facility, etc.) to:</p> <ol style="list-style-type: none"> <li>1. Arrange a follow-up visit or other CARE STEP at the health center, or</li> <li>2. Speaks with patient to update care plan and educate on preventive health measures, or</li> <li>3. Assists patient with a transition in their care setting.</li> </ol>	<p>This Care STEP should be counted when health center staff have verified the patient received or needs to receive health services from a different provider, and completed 1, 2, or 3 listed in the definition section.</p>
<b>COORDINATING CARE: DENTAL</b>	<p>During primary care visit, patient and health center staff identify that patient has dental health care needs, and coordinates with dental professionals by assistance with dental appointment set-up or follows up with patient about dental health care needs.</p>	<p>This Care STEP should be counted when health center staff have confirmed that the primary care provider set-up a dental appointment and/or has followed up with the patient about their dental health care needs.</p>
<b>BEHAVIORAL HEALTH AND FUNCTIONAL ABILITY SCREENINGS</b>	<p>Health center staff facilitates the completion of standardized screening tools that assess patient’s needs or status relating to behavioral health, functional ability and quality of life in order to organize next steps in a care plan. Screening tools include behavioral, mental health, developmental, cognitive or other functional screening tools, either through interview or patient self-administration of a screening form.</p>	<p>This Care STEP should be counted when completion of the screening process has been initiated to support care and service planning in collaboration with the patient.</p>
<b>WARM HAND-OFF</b>	<p>Health center provider or health professional conducts a face-to-face introduction for the patient to a provider or health professional of a different health discipline (e.g. primary care physician introduces patient to a behavioral health consultant or community health worker).<sup>6</sup></p>	<p>This Care STEP should be counted when the patient is successfully introduced to the second provider or health professional.</p>

## REDUCING BARRIERS TO HEALTH

CARE STEP	DEFINITION	USE
<b>SOCIAL DETERMINANTS OF HEALTH SCREENING</b>	Health center staff facilitate the completion of a Social Determinants of Health screening questionnaire with the patient, either through interview or patient-self administration of a screening form.	This Care STEP should be counted when the screening process has been initiated to support care and service planning in collaboration with the patient.
<b>CASE MANAGEMENT</b>	Case management is a process in which a provider or another qualified health care professional <sup>7</sup> is responsible for direct care of a patient and, additionally, for coordinating, managing access to, initiating, and/or supervising other health, social or other kinds of services needed by the patient. In order to use this Care STEP category, the health center must be able to identify who the assigned case manager is in the patient health record.	This Care STEP should be counted, once a case manager is assigned to the patient, for all interactions where the case manager directly interacts with the patient or family/representative relating to direct care, coordination of care, managing patient's access to care or initiation and/or supervision of other health care services needed by the patient.
<b>ACCESSING COMMUNITY RESOURCE/SERVICE</b>	Patient or family/representative is educated on available resources in their community based on a presenting need (such as assisting with immigration paperwork, finding domestic violence resources, obtaining legal services, medication assistance program registration, financial assistance, donations including clothing, infant supplies, medical equipment, prostheses, assistance finding employment, education opportunities, shelter) AND health center staff refers or connects the patient to the resource/service.	This Care STEP should be counted when health center staff educates the patient and/or family on available resources AND refers/connects the patient to the resource
<b>TRANSPORTATION ASSISTANCE</b>	Health center provides direct assistance to a patient by a staff member or contractor to arrange or provide transportation resources and services to reduce access barriers for the patient.	This Care STEP should be counted after staff identify patient has an access barrier in the realm of transportation AND delivers the resource/service that will reduce the transportation barrier.

## EXAMPLE FQHC APM RECONCILIATION REPORT

### CALENDAR YEAR 2016

APM PAYMENTS	\$3,499,860
MEDICAID MANAGED CARE PAYMENTS	\$2,500,680
TOTAL MEDICAID REVENUE	\$6,000,540

TOTAL BILLABLE MEDICAID VISITS	39,000
PPS RATE	\$150.00
PPS EQUIVALENT REVENUE	\$5,850,000

HEALTH CENTER RECEIVED AT LEAST WHAT THEY WOULD HAVE RECEIVED UNDER PPS	YES
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## ENDNOTES

<sup>1</sup>Joynt, K. E. et al. (2017). Should Medicare Value-Based Purchasing Take Social Risk into Account? *N Engl J Med*, 376(6), 510-513. doi:10.1056/NEJMp1616278

<sup>2</sup>NACHC's *Payment Reform: Supplement to Governing Board Workbook* is designed to help health center board members understand changes to health center payment and care models. To access this resource, visit the [MyNACHC Learning Community](#).

<sup>3</sup>Most Medicaid programs have different Medicaid benefit or enrollment categories. These benefit categories typically include consideration of age, gender, disability status, Medicare dual-eligible status, and Medicaid expansion. The State develops and tracks these categories to review enrollment and spending in each category. These categories may also be the basis for payment to managed care organizations.

<sup>4</sup>Under Section 1902 of the Social Security Act (SSA), each state is required to have a state Medicaid plan reviewed and approved by CMS that describes the nature and scope of the state's Medicaid program, e.g., covered services, reimbursements to providers, eligibility requirements. (See, 42 CFR 430, Subpart B) States are required to administer their programs in accordance with the state Medicaid plan, but may seek to change administrative aspects of their programs through the use of a SPA.

<sup>5</sup>In general, whenever there is a change in federal law, regulations, policy interpretations or court decisions, a state's Medicaid plan will require an amendment. Also, when there is a material change in state law, organization, or policy, or in the state's operation of its Medicaid program, a state will be required to submit an amendment. (42 CFR § 430.12) In either event, each state Medicaid plan and any amendment thereto (i.e., a SPA) must be reviewed and approved by CMS. (42 CFR § 430.12(c)(2), 14, 15(b)-(c)).

<sup>6</sup>Under BIPA, the FQHC Medicaid PPS requires states to make payments for FQHC/RHC services in an amount calculated on a per-visit basis that is equal to the reasonable cost of such services documented for a baseline period, with certain adjustments.

<sup>7</sup>Part 447 of 42 CFR outlines administrative rules regarding payments for services, and describes the state Medicaid plan requirements for setting payment rates. 42 CFR § 447.205 describes the public notice requirement. (See, also, 42 CFR 430.20(b)(2) and 447.256(a)(2))

<sup>8</sup>The rules specify that governor's review is not required if 1) the designee is head of the state's Medicaid agency, or 2) the state is submitting a preprinted plan amendment for which it has no option. (42 CFR 447.12(b))

<sup>9</sup>42 CFR § 447.203(b)(6). Also, see generally, 42 CFR 447.203-.205 regarding recipient access and provider protections relating to change in payments.

<sup>10</sup>42 CFR § 447.204

<sup>11</sup>42 CFR § 430.16

<sup>12</sup>42 CFR § 430.16 specifies that approvals can be sent by either the Regional Administrator or the Administrator [of the Center for Medicare and Medicaid Services].. However, only the Administrator may give notice of disapproval.

<sup>13</sup>42 CFR § 430.20

<sup>14</sup>Conversely, the waiver process is utilized by the state when seeking to have certain federal Medicaid requirements waived. Waivers are approved for a limited amount of time, while SPAs are permanent unless changed through a subsequent SPA.

<sup>15</sup>See CMS SMD letter #10-020, dated October 1, 2010

<sup>16</sup>Ibid.

<sup>17</sup>See 42 CFR §§ 430.18 and 430.102. Also, the Administrative Procedure Act at 5 USC §551 et seq. Several states also have an administrative procedure act to codify the process by which agencies take actions.

<sup>18</sup>For PCAs reviewing the policies related to the current FQHC PPS/APM to ensure the rate appropriately reflects the services the health centers provide before developing a new FQHC APM, see [NACHC's Medicaid Prospective Payment System Checklist](#).

<sup>19</sup>CMS. MLN Matters Number MM9831 (Revised). Available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net-work-MLN/MLNMattersArticles/Downloads/MM9831.pdf>.

<sup>20</sup>Tobacco cessation and maternity case management are excluded from this category because these types of telephone calls are billable encounters, as long as they include all of the same components of a face-to-face visit, in accordance with OAR 410-147-0120 Section 4. Retrieved from [http://arcweb.sos.state.or.us/pages/rules/oars\\_400/oar\\_410/410\\_147.html](http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_147.html).