

Medicaid FQHC Prospective Payment System Checklist

Federal law requires that State Medicaid agencies pay federally-qualified health centers (FQHCs or “health centers”) using a prospective payment system (PPS). This **Medicaid FQHC Prospective Payment System Checklist** is designed to assist FQHCs and Primary Care Associations (PCAs) in assessing FQHCs’ PPS rates and in pursuing strategies to make the PPS methodology work better.

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) established a Medicaid FQHC PPS, effective in 2001, to pay for a comprehensive range of services furnished by FQHCs. The PPS is a fixed, per-visit rate reflecting 100% of the center’s reasonable costs of furnishing FQHC services during a base period. Each FQHC has a unique PPS rate based on its allowable costs. The PPS rate is trended forward annually by an inflation index (the Medicare Economic Index, or MEI), and must be adjusted as needed to reflect changes in the scope of service furnished by the center. In the managed care context, States are required to make supplemental (or “wraparound”) payments to FQHCs to cover the difference between amounts paid to the FQHC by a Medicaid managed care entity and the FQHC’s PPS rate (if higher).

Under federal law, States may choose to use an alternative payment methodology (APM) instead of the FQHC PPS. However, a State’s payments to FQHCs under an APM must be at least equal to what an FQHC would have received under PPS, and additionally, States may enforce an APM only if the affected FQHC agrees to it. In addition, the APM must be set forth in the Medicaid State plan.

The Medicaid FQHC PPS methodology is described in Section 1902(bb) of the Social Security Act (SSA). In this Checklist, we briefly summarize each provision of the law relating to the PPS, and then identify issues that health centers and PCAs should examine with respect to each aspect of the methodology as it impacts them. We also identify common areas of State Medicaid policy relating to provider enrollment and FQHC billing that may pose challenges to FQHCs.

Setting of Initial PPS Rates [SSA §§ 1902(bb)(1) and (2)]

BIPA 2000 established a Medicaid FQHC PPS methodology for FQHCs, effective for services furnished on or after January 1, 2001.

Each FQHC’s unique initial PPS rate was based on the FQHC’s fiscal year (FY) 1999 and FY2000 reasonable costs per visit. The formula on which each FQHC’s initial PPS rate is based is as follows:

100% of the average service costs of the FQHC during FYs 1999 and 2000

of FQHC visits in FYs 1999 and 2000

The FQHC PPS rate includes those costs that are “reasonable and related to the costs” of furnishing services. States were allowed to use certain “tests of reasonableness,” as set forth in Medicare regulations, but only if those limitations did not result in limiting FQHCs’ actual allowable costs. States were required to adjust the baseline per-visit PPS rate to take into account any change in the scope of services during FY2001.

Two categories of services are encompassed in the bundled, cost-related FQHC PPS rate. “FQHC services” are defined as the services of physicians, physician assistants, nurse practitioners, clinical psychologists, and clinical social workers, and may include the services of visiting nurses in the case of health centers in areas with a shortage

of home health agencies. The FQHC benefit also includes any other ambulatory services that are offered by an FQHC and are included in the Medicaid State plan.

The initial FQHC PPS rate is important, because the rates for each ensuing fiscal year are based on the initial year's rate. Mistakes or limitations embedded in the initial rate continue to have an impact in later years.

IN ASSESSING FQHCS' INITIAL PPS RATES, FQHCS AND PCAS SHOULD:

1. Review the State's methodology for setting initial PPS rates and documentation supporting the rates.

Is the methodology for setting initial rates set forth in the State plan?

Has the FQHC retained cost reports and other documentation relevant to the base-year rates?

Did the State rely on Medicare FQHC cost reports, or develop its own State-specific Medicaid cost report template?

2. Identify any cost limitation devices that the State applied in determining the FQHC's allowable costs in the base years. For example, did the State employ any of the following?

Rate ceilings (for example, limiting rates to the FQHC urban and rural upper payment limits used formerly used in the Medicare program)

Administrative cost caps (for example, limiting allowable administrative costs to 25% of overall costs)

Caps based on other health centers' rates (for example, statewide averages or "peer groups")

Required offset of certain revenues (for example, grant revenues) from allowable costs

3. Evaluate whether the clinical costs on the cost report include the full scope of "FQHC services" and "other ambulatory services."

Does the cost report include the full scope of core "FQHC services" in allowable clinical costs – for example, are all "physician" types (including dentists, podiatrists, osteopaths, and chiropractors, where applicable) included?

Does the cost report include the full scope of "other ambulatory services" covered under the State plan (for example, speech, occupational, or physical therapy, services of licensed professional counselors, as applicable)?

4. Identify any other policies used in measuring base-year costs that may result in FQHCs not receiving the full cost-related PPS rate for covered services.

Does the State pay for certain components of the FQHC benefit, such as dental and behavioral health services, by "carving the costs out" of the FQHC cost report and paying for them on a fee-for-service basis?

Does State pay less than the full PPS rate (a "mini PPS rate") for certain types of visits assumed to be less cost-intensive, such as group therapy services?

Does the State include cost-intensive inpatient services, such as deliveries, within the FQHC PPS rate, without any supplemental payment to account for their associated costs? (Please note that in general, the FQHC benefit includes only services furnished on an outpatient basis.)

5. Evaluate the definition of billable "visits" used for establishing the initial rate.

Did the State require the use of provider productivity standards (sometimes called "screens") in developing the visit count for the base rate? (Under a productivity standard, a minimum number of visits is imputed to each provider for purposes of the visit count in the cost report – for example, 4200 visits/year per physician, or 2100 visits/year per nurse practitioner.)

Does the State impose a “visit” definition for present FQHC billing purposes that is more restrictive than the “visit” definition that was used to develop the visit count for purposes of the initial FQHC PPS rate? (Please see “Billing Limitations” below.)

Mandatory Adjustment of PPS Rate: Inflationary Adjustment (Medicare Economic Index) and Adjustments to Reflect Changes in the Scope of Services [SSA § 1902(bb)(3)]

For FY2002 and fiscal years thereafter, State Medicaid agencies are required to pay FQHCs at a rate equal to the previous year’s PPS rate, adjusted by an inflationary index – the Medicare Economic Index (MEI) applicable to primary care services. States are also required to adjust an FQHC’s PPS rate to take into account any increase or decrease in the scope of services furnished by the FQHC. A “change in the scope of services” has been defined in a 2001 guidance from the Centers for Medicare & Medicaid Services (CMS) as “a change in the type, intensity, duration and/or amount of services.” States are required to describe the process for scope change rate adjustments in the Medicaid State plan.

IN ASSESSING STATES’ POLICIES CONCERNING ADJUSTMENTS TO THE MEDICAID FQHC PPS RATES, FQHCS AND PCAS SHOULD:

1. Evaluate the State’s process for adjusting rates to reflect the MEI.

Does the State apply the correct MEI factor to the corresponding time period?

Does the State reconcile the FQHC’s rate retrospectively if a provisional inflation factor is used until the correct MEI is published?

Does the Medicaid State plan address MEI rate adjustments under the FQHC PPS?

IN ASSESSING STATES’ POLICIES CONCERNING FQHC PPS RATE ADJUSTMENTS TO REFLECT CHANGES IN THE SCOPE OF SERVICES, FQHCS AND PCAS SHOULD:

2. Analyze the Medicaid State plan (and any State laws, regulations, and guidance) regarding PPS change-in-scope rate adjustments.

Does the Medicaid State plan describe the process and standards for change-in-scope PPS rate adjustments?

How does the State define the categories of events that can trigger a change in the scope of services? Do the triggering events include all types of events described in the guidance (changes in type, intensity, duration, or amount of services)?

In situations where a State has not had an effective rate adjustment policy in place in prior years, does the State have in effect a policy to adjust rates to reflect the cumulative effect of prior years’ changes in scope?

3. Identify any State policies that may limit FQHCs’ access to a change-in-scope rate adjustment.

Does the State require that a minimum cost change threshold be met (e.g., a change must result in an increase of at least X% of annual allowable service costs) before a center may request a rate adjustment?

Does the State impose temporal restrictions concerning applications for a rate adjustment, such as the following?

- Requiring health centers to obtain State approval of a change in the scope of service prior to the date a center implements the change
- Recognizing for purposes of a rate adjustment only those changes in the scope of service that occurred less than one year before the center submitted the application
- Implementing rate changes only prospectively, rather than adjusting the center’s PPS rate to take effect as of the date the center first implemented the change in scope of service

Under State policy, do some types of change-in-scope PPS rate adjustments expire after a limited time? (for example, State policy provides that a rate adjustment to account for adoption of an electronic health record (EHR) system expires after two years, due to the expectation that efficiencies resulting from the adoption of EHR will reduce costs)

Does the State accept only those changes in scope that correspond to changes in the center's scope of project under its operating grant from the Health Resources and Services Administration (HRSA)?

4. Review rate adjustment application processes and required cost report documentation.

Does the State require the center to submit a full or partial cost report for the year(s) affected by the changes?

PPS Rates for "New Start" FQHCS [SSA § 1902(bb)(4)]

Under federal law, for entities that first qualify as a FQHC after FY2000 ("new start" FQHCS), the PPS rate is established differently than for those health centers that existed as FQHCS in FYs 1999 and 2000. Specifically, for new start FQHCS, the rate for the first year that the FQHC qualifies as such is set based on the rates established for FQHCS in the same or adjacent areas with a similar case load or on other tests of reasonableness. As with FQHCS existing at the time of passage of BIPA, new start FQHCS' PPS rates must subsequently be adjusted annually for MEI and must be adjusted to reflect changes in the scope of service.

IN ASSESSING STATES' POLICIES WITH RESPECT TO NEW START FQHCS, FQHCS AND PCAS SHOULD:

1. Review the Medicaid State plan provisions addressing interim initial rates for new start FQHCS.

Does the State plan describe a methodology for determining the average costs of other FQHCS in the same or adjacent area with a similar case load, for purposes of the interim rate as required by statute if the State chooses that option? Or is the process described only in State regulations or other protocols?

Does the State define "same or adjacent area" or "similar case load" based on clear and logical criteria?

2. Review the Medicaid State plan provisions addressing final, "settled" rates for new start FQHCS.

Does the State provide a mechanism for the new start FQHC's own cost report to be used to as the basis for its PPS rates in years after the initial year?

Does the State plan provide for a reconciliation to apply the new start's own cost-based rate to an initial year when the new start was paid under an interim rate derived from other health centers' costs?

Does the State plan provide for adjusting the new start FQHC's PPS rate to reflect the MEI and any change in the scope of services (as applicable)?

Wraparound/Supplemental Payments for Services Furnished Under Contract with a Managed Care Organization ("MCO") Related Issues [SSA § 1902(bb)(5)]

Under federal law, States are required to make payments to FQHCS to cover the difference between amounts paid to the FQHC by a Medicaid managed care organization (MCO) and the FQHC's PPS rate (if the latter is higher). These supplemental payments, which are made directly from the State to the FQHC, are sometimes referred to as "wraparound" payments. Federal law also requires that States, in their contracts with MCOs, ensure that MCOs pay FQHCS no less than the MCO would pay a provider that is not an FQHC for the same services (see SSA § 1903(m)(2)(ix)).

Today, Medicaid managed care is expanding rapidly nationwide, with 68% of Medicaid beneficiaries enrolled in comprehensive managed care in 2016, up from 51% in 2011. As a result, policy issues concerning the intersection of managed care and the PPS system are prominent for FQHCS.

CMS issued guidance concerning FQHC wraparound payments in April 2016, advising that States may amend their State plans in order to require MCOs to pay contracted FQHCS the full PPS rate for covered services. CMS stated that

States may delegate the wraparound payment obligation to MCOs in this manner only if they use a CMS-approved alternative payment methodology (APM) (see below).

The law also requires that States ensure that either the State or the MCO pays for out-of-network services furnished to a Medicaid MCO enrollee by a provider (including an FQHC) where the services were immediately required because of an unforeseen illness or injury.

IN ASSESSING STATES' POLICIES WITH RESPECT TO SUPPLEMENTAL PAYMENTS TO FQHCS, HEALTH CENTERS AND PCAS SHOULD:

1. Review Medicaid State plan provisions concerning timing of wraparound payments.

Does the State plan describe the methodology and timeframes in detail?

Is the State required to make wraparound payments at least every four months, as required by federal law?

Is the State required to conduct a timely reconciliation of wraparound payments made on a provisional basis?

In FQHCs' experience, does the State adhere to these timeframes and policies?

2. Review Medicaid State plan provisions concerning calculation of wraparound payments.

Where MCO pays the FQHC on a capitated basis, does the State correctly convert capitated MCO payments to a per-visit amount for the purposes of calculating the required supplemental payment?

Does the State offset from its wraparound payment to the FQHC amounts paid by the MCO to the FQHC for services that are not part of the FQHC benefit, such as the following?

- Payments for add-on services
- Payments that MCO, by contract, requires the FQHC to pass through to third-party providers
- Incentive or bonus payments

Does the State have a "paid claim policy" whereby the State refuses to provide wraparound on a claim unless the MCO pays it first?

3. If a State has elected to delegate the wraparound obligation to MCOs, evaluate the following.

Is this methodology included in the State plan as an APM? Did FQHCs have the opportunity to accept or reject the APM?

Does the State have policies in place to monitor MCO implementation of prior authorization and other utilization control policies to ensure that MCOs are correctly applying these policies?

Does the State have procedures in place to monitor MCO network adequacy and ensure that delegation of PPS payment to MCOs is not resulting in inadequate network participation by health centers?

4. With respect to out-of-network services, evaluate the following.

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

Is the State paying FQHCs for non-urgent, yet covered Medicaid services furnished to out-of-network MCO enrollees?

FQHC Alternative Payment Methodology (“APM”) [SSA § 1902(bb)(6)]

Under federal law, States are allowed to use an APM instead of the PPS methodology, if the State complies with several conditions. First, a State’s payments to FQHCs under an APM must be at least equal to what the FQHC would have received under PPS. In addition, States may enforce an APM with respect to an FQHC only if that FQHC agrees to it. Any APM must be set forth in the Medicaid State plan.

IN ASSESSING STATES’ POLICIES WITH RESPECT TO APMS, FQHCs AND PCAS SHOULD:

1. Determine how State documents the APM and demonstrates that it has obtained individual FQHC agreement to the APM.

Is the APM included in an approved State plan amendment?

Is the APM agreement with each FQHC in writing?

Does the agreement give the FQHC an opt-out or phase-out process if the FQHC decides to withdraw from the APM agreement?

Does the State notify the FQHC annually of its APM and PPS rates?

2. Determine how/whether the State ensures that FQHCs under an APM rate are paid at least the PPS rate annually.

Is the State updating its PPS rate accurately for purposes of the comparison? For example, does the State:

- Adjust PPS rates annually to reflect the MEI?
- Maintain a change-in-scope PPS rate adjustment process available to FQHCs paid under an APM?

If the APM involves the use of capitation payments or risk-based bonus payments, does the State have a mechanism in place to convert and compare the capitation payment to the PPS rate?

If the APM involves the use of a retrospective cost reimbursement methodology similar to the methodology that applied under Medicare for FQHCs until FY 2014:

- Does the State impose upper payment limits or provider productivity screens such as those that applied under the former Medicare methodology?
- Does the State timely settle FQHC cost reports to reconcile interim payments based on a prior year’s costs?

Does the State have a process in place to pay health centers at the PPS rate rather than the APM, where PPS rate exceeds payments under the APM over the course of the fiscal year?

FQHC Provider Enrollment Requirements, PPS Billing Limitations, and Medicaid Third-Party Liability

The considerations below do not relate to specific requirements for FQHC PPS in Section 1902(bb) of the SSA, but instead to State policies that may impede FQHCs from participating in Medicaid, from seeking payment for the full range of services furnished, or from receiving their full PPS rate as payment.

In general, an FQHC “visit” is defined under State rather than federal law. The “visit” is both the unit for allocating costs under the PPS rate, and the billable event for purposes of receiving payment under Medicaid for care provided. To adhere to federal law, States should define a “visit” so as to ensure that FQHCs are paid for the full range of FQHC and other ambulatory services (see above). In addition, where States use a definition of a “visit” for present billing purposes that is more restrictive than the definition that was used for purposes of establishing the initial PPS rate, the result may be that FQHCs do not effectively receive the full PPS rate.

With respect to dual-eligible beneficiaries and individuals who have private insurance coverage in addition to

Medicaid, Medicaid serves as “payor of last resort.” After the FQHC bills the primary payor, Medicaid, as secondary payor, should pay the FQHC an amount equal to the difference between what the FQHC received from the primary payor, and the PPS rate (if higher).

WITH RESPECT TO PROVIDER ENROLLMENT POLICIES, HEALTH CENTERS AND PCAS SHOULD EVALUATE THE FOLLOWING:

- 1. Does the State require each site of an FQHC to enroll as a separate Medicaid provider (as is the case in the Medicare program)?**
- 2. Does the State impose Medicare provider enrollment as a prerequisite to Medicaid enrollment?**
- 3. In the context of managed care, do MCOs conduct timely credentialing of FQHC clinicians, so as to enable the FQHC to bill the MCO for services promptly after the contract is in place?**

WITH RESPECT TO FQHC BILLING LIMITATIONS, HEALTH CENTERS AND PCAS SHOULD EXAMINE THE FOLLOWING:

4. Any limitations on the definition of FQHC “visit” relating to the type or modality of care.

Does the State require FQHCs to “bundle” multiple services into a single encounter (e.g., dental cleaning and dental exam) or refuse to pay for multiple services provided in separate encounters?

Does the State limit billable visits to those that take place at an FQHC site (a “four walls” rule)?

Does the “visit” definition allow FQHCs to bill for encounters furnished through telehealth technologies?

Does the “visit” definition include the same limitations that are used in the Medicare program (such as denying payment for more than one visit furnished on the same day, unless the visits are of different types)?

Does the State impose numerical caps on certain types of visits? (for example, skilled therapies or behavioral health)

5. Any limitations on the types of health care providers who may furnish a billable visit:

Does the definition of an FQHC “billable provider”:

- Include all categories of professionals who are qualified to furnish “FQHC services” under the statute (physicians, PA, Nurse practitioners, nurse midwives, visiting nurses, clinical psychologists, licensed clinical social workers, etc.)?
- Include all or most of the professionals who are qualified to furnish “other ambulatory services” (e.g., speech or occupational therapists, licensed professional counselors, etc.)?

If the State imposes physician supervision requirements with respect to non-physicians in furnishing FQHC visits, do those requirements as a practical matter impede some types of clinicians (e.g., clinical psychologists) from providing services in FQHCs?

WITH RESPECT TO BILLING RULES FOR FQHC PATIENTS WHO HAVE MEDICARE OR OTHER INSURANCE IN ADDITION TO MEDICAID, HEALTH CENTERS AND PCAS SHOULD ASK:

- 1. For Medicare-Medicaid dual-eligible beneficiaries who are FQHC patients, does the State pay an FQHC up to the full PPS rate, or does the State cap Medicaid’s payment at the amount of Medicare coinsurance?**
- 2. For FQHC Medicaid patients who also have private insurance, does the State (and MCOs, if applicable) provide for an effective and prompt secondary claims payment process?**

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