The FQHC Medicaid Prospective Payment System:
The Basics

Tennessee Primary Care Assn.
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PRESENTER: EDWARD “TED” WATERS

• Well known for his expertise in federal grants, government reimbursement, payment and administrative issues, and his strategic handling of organizations facing crises, Ted was again selected this year as a “Super Lawyer” for Health Care in Washington, D.C.

• Ted has been counsel to countless health centers and other recipients of federal funds in the past 25 years as well as many other entities such as managed care organizations and federal contractors, and has represented clients in front of federal and state courts, administrative tribunals, Offices of Inspector General and federal agencies to name a few.

• Ted has been Managing Partner of Feldesman Tucker since 2003 and last year started the first law school class in the country on federal grant programs at the George Washington University School of Law.

• Contact Information: Ewaters@ftlf.com or 202.466.8960

AGENDA

• Identify the sources of law that govern State’s payment to FQHCs under Medicaid
• Identify the range of services covered in the Medicaid FQHC PPS reimbursement methodology
• Identify the legal requirements for:
  – Establishment of a health center as an “FQHC” in the Medicaid program
  – Establishment and routine adjustment of the PPS rate
  – Supplemental (or “wraparound”) payments to health centers for services provided under contract with Medicaid managed care organizations
  – Alternative payment methodologies (“APM”)
• For each topic above, describe contentious current issues in State Medicaid programs
BEGINNING:

The road to success is always under construction.

- Lily Tomlin

AS EXPLAINED BY THE 2ND CIRCUIT

We are concerned here with two competing objectives: “the mission of publicly-funded health clinics to provide a panoply of medical services to underserved communities, on the one hand,” . . . , and the necessity that there be a “measure of discretion [states have] in choosing how to expend Medicaid funds,” . . . , on the other. This measure of discretion, in turn, is premised on the recognition that states receiving Medicaid funds must be permitted to develop Medicaid programs that are responsive to the needs of their respective communities, so long as these programs are consistent with federal Medicaid requirements . . .
Sources of Law Governing Medicaid FQHC Reimbursement

SOURCES OF LAW – FQHC MEDICAID REIMBURSEMENT

Federal law

- The Social Security Act (see SSA §§ 1861(aa), 1902, and 1905)
- Federal regulations (see 42 C.F.R. Parts 438, 440 and 447 governing Medicaid services and provider payment, but NOTE that there are no regulations implementing FQHC PPS)
- Federal guidance, such as Dear State Medicaid Director Letters (“SMDLs”)

Federal-State agreements:

- The Medicaid State Plan, describing material aspects of covered services and reimbursement
  - Each plan provision (and revision) must be approved by CMS
  - States seek approval of State Plan provisions based on CMS-generated “preprints”
  - States must administer Medicaid benefits in accordance with State Plan
- Waiver documents (1115 demonstrations, Section 1915(b) and (c) waivers)
SOURCES OF LAW – FQHC MEDICAID REIMBURSEMENT, CONT.

State law
– State legislation
– State regulations
– State provider guidance, billing manuals
– Provider Agreements

Scope of Medicaid FQHC Benefit
The services reimbursed under the PPS methodology include “Federally-qualified health center services” and “other ambulatory services”.

“Federally-qualified health center services” including:
- Physicians’ services and “incident-to” services
- Services furnished by a physician assistant, nurse practitioner, clinical psychologist, or clinical social worker, and “incident-to” services
- Must be when furnished to an individual “as a patient of a Federally-qualified health center”

SSA §§ 1861(aa)(1), 1905(l)(2)(B))

“Other ambulatory services” must be:
- Ambulatory (outpatient) services, AND
- Offered by the FQHC, AND
- Otherwise included in the STATE plan

SSA § 1905(a)(2)(C)

SCOPE OF BENEFIT – CONTENTIOUS ISSUES

States may limit the scope of the FQHC benefit unlawfully. Some examples:

- Failing to recognize all “physicians’ services” as covered within FQHC benefit
  - Note: “physicians’ services” includes the services of dentists, podiatrists, chiropractors
- Failing to recognize all “core” behavioral health services (e.g. therapy furnished by clinical psychologists and licensed clinical social workers) as within FQHC benefit
- Limiting “other ambulatory services” so that this term in fact does not reflect all services covered under the state plan
  - Watch out for conflicts between State Plan (which typically states that all “other ambulatory services” are covered) and state regulations (which often limit/enumerate scope of those services)
SCOPE OF BENEFIT – CONTENTIOUS ISSUES, CONT.

• “Carving out” specific services (e.g., dental, behavioral health, podiatry, optometry) from PPS and paying on (lower) FFS basis
• Defining allowable FQHC services as excluding “off-site” services
  – FQHC services include only services provided to “patients of” the FQHC; however, federal law does not restrict the provision of services to an FQHC’s dedicated patients in other locations, such as patients’ homes or group living facilities
• Prohibitions on billing under the FQHC benefit for hospital “rounding” – even when services are of same type provided in the health center and provided to health center patients

Qualifying as an FQHC
QUALIFYING AS AN FQHC FOR MEDICAID

A Medicaid FQHC is an entity which:

- Is receiving a grant under section 330 of the Public Health Service Act, **OR**
- Is receiving funding from such a grant under a contract with the recipient of such a grant, and meets the requirements to receive a grant under section 330 of such Act [*i.e., a subrecipient*], **OR**
- Based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant, including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity [*i.e., a "look-alike*], **OR**
- Was treated by the Secretary, for purposes of Medicare Part B, as a comprehensive Federally funded health center as of January 1, 1990.

Term includes outpatient health programs operated by tribes or tribal organizations or by urban Indian organizations.

SSA § 1905(l)(2)(B)

QUALIFYING AS AN FQHC – CONTENTIOUS ISSUES

- Some States require Medicare site certification as a prerequisite for Medicaid FQHC status
  - Progress on this front; several states have recently dropped that restriction
- “New starts” (grantee or look-alike) may experience operational delays relating to obtaining and implementing Medicaid managed care contracts
Establishment of Initial (2001) FQHC PPS Rate

ESTABLISHMENT AND ADJUSTMENT OF INITIAL (2001) PPS RATE

- The PPS rate is an individually determined “per visit rate” for “FQHC Services” and “any other ambulatory services” provided for in the State Plan.
- The methodology is referred to as a “prospective payment” system because per-visit rate is based on allowable costs per visit in a base year, trended forward - payments not annually reconciled against allowable costs.
- The initial PPS payment rate for services provided on and after January 1, 2001 was equal to:
  - 100 percent of the average of the costs of the center or clinic of furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in [Medicare] regulations . . ., adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001.

Social Security Act § 1902(bb)(2)
INITIAL PPS RATE – CONTENTIOUS ISSUES

Little or no available information on how States set initial (baseline) PPS rates
- Underlying documentation and analysis rarely shared with centers
- Rate setting process is often unexplained

In setting the original Medicaid PPS rate, many states applied wholesale the Medicare cap (separate per-visit ceilings for rural and urban health centers) and productivity screen (minimum annual billable encounters by provider type)
- CMS stated this was impermissible in a 1995 guidance – instead, the Medicare cost containment mechanisms could be used in Medicaid only “if the State determines and assures [CMS] that [the rate] covers the FQHC’s reasonable cost for both core and other ambulatory services”
- Federal courts in Maryland and Connecticut reached the same conclusion

INITIAL PPS RATE – CONTENTIOUS ISSUES

Use of cost-limiting devices without support - come in several varieties:
- Cap on PPS rate based on “average” per-visit rate statewide
- Caps (or ceilings) on allowable cost categories (medical, dental, behavioral, ancillary, transportation) based on regional averages
- Cap on just administrative costs (e.g., 30% or some other arbitrary percentage of overall costs)
- Excluding federal, state, local, or private grant funds from FQHC allowable costs
Billable Encounters

BILLABLE ENCOUNTERS

• For Medicaid (unlike Medicare), federal law does not define billable FQHC encounters
• If a service or activity falls within the FQHC’s allowable costs but does not constitute a billable encounter, then the FQHC is theoretically reimbursed for the activity because its costs are embedded in the encounter rate
  – This is true only if States maintain working change-in-scope procedures
COMMON STATE RESTRICTIONS ON BILLABLE ENCOUNTERS

- Requiring FQHCs to “bundle” multiple services (e.g., tooth cleaning and dental examination) in one encounter despite PPS rate premised on two encounters
- “4 walls” rules providing that billable encounters must be in the FQHC site even though off-site services are included in Section 330 Scope and Medicaid statute authorizes off-site physician services
- “One visit per day” rule, or one medical and one dental visit per day
- States have considerable discretion in defining billable encounters (because of lack of federal definition of “encounter” for Medicaid FQHC reimbursement), but if encounter definition is changed in a way that makes previously billable encounters non-billable, the health center should have the opportunity to seek a change-in-scope rate adjustment

Establishment and Adjustment of PPS Rate - 2002 and Subsequent Years
ESTABLISHMENT AND ADJUSTMENT OF PPS RATE – 2002 AND SUBSEQUENT YEARS

For 2002 and succeeding years, the PPS rate is equal to the PPS rate calculated for the prior year,

– Increased by the percentage increase in the Medicare Economic Index (MEI), and

– Adjusted to take into account any increase or decrease in the scope of services provided during that fiscal year

Social Security Act § 1902(bb)(3)
Per CMS guidance, a “change in the scope of services” is a “change in the type, intensity, duration, and/or amount of services” and must include changes in the scope of services that do not include a face-to-face visit with a provider (e.g., outreach, case management, drugs)

PPS IN 2002 AND SUBSEQUENT YEARS – CONTENTIOUS ISSUES

• Failing to establish any change-in-scope process or policy as required by the statute, including:
  – No process at all for an FQHC to apply for a change-in-scope rate adjustment
  – Unpublished process (secret or ad hoc)
  – Incomplete process
    • Lack of definition of qualifying events or partial definition (generally, include “type” but nothing on intensity, duration, amount)
    • Lack of process for established amount of adjustment
      – Percentage differences that operate as barrier to adjustment (ex. 5% threshold)
    • Lack of process to request adjustment
  • Insisting on leaving the scope change policy out of the state plan, in a more informal policy guidance, and then never issuing the guidance or not implementing it once written
  • Failing to account for many years of changes; after the state implements a procedure, it provides no means to account retrospectively for past changes in scope
RATE-SETTING FOR “NEW STARTS”

A “New start” is a center that first qualified as FQHC after FY 2000.

Section 1902(bb)(4) requires such centers have an initial PPS rate that is:

- based on “the rates established under this subsection for the fiscal year for other such centers . . . located in the same or adjacent area with a similar case load or,
- in the absence of such a center or clinic, in accordance with the regulations and methodology referred to in paragraph (2) [the initial PPS rate methodology] or
- based on such other tests of reasonableness as the Secretary may specify.
NEW STARTS – CONTENTIOUS ISSUES

• Some states set interim rate for new starts and, after a period of time, use the center’s actual cost data to establish a baseline PPS rate, but without reconciliation between interim and actual rate or say they will set a cost-based rate and never do.

• Some states fail to provide for a means for a new start to establish a rate using its own costs, where the adjacent health centers do not have “similar case loads”.

Supplemental Payments for Services Provided in Managed Care (“Wraparound”)
SUPPLEMENTAL PAYMENTS
(“WRAPAROUND”)

• In the case of services furnished by an FQHC pursuant to a contract with a Medicaid MCO, the State plan must provide for payment to the FQHC by the State of a supplemental payment “equal to the amount (if any) by which the amount determined under [the PPS or APM methodology] exceeds the amount of the payments provided under the contract”
  • Social Security Act § 1902(bb)(5)(A)
• The payments must be made according to an agreed-upon schedule, but “no in no case less frequently than every 4 months”
  • Social Security Act § 1902(bb)(5)(B)
• Per CMS guidance, states must conduct a “reconciliation” annually, or more frequently at State option, to ensure that MCO payments plus supplemental payments are equal to the PPS/APM amount

WRAPAROUND – CONTENTIOUS ISSUES

❑ Refusing to pay wraparound on a claim unless the MCO pays the claim first. Often referred to as a “paid claim” policy. These policies come in several varieties – e.g.:
  • Center may submit claims for MCO payment and interim wraparound rate simultaneously, but if no MCO payment received, center is not entitled to wraparound and State takes back interim wrap.
    • Backwards – if MCO fails to pay bona fide claim, State owes full PPS rate, not nothing.
  • Exclude MCO visits from reconciliation entirely.
  • Include MCO visits in reconciliation under accrual method of accounting where expected MCO payment is imputed (as opposed to actual). If center is never paid “imputed” amount, State never pays full PPS, as required, and only pays difference between imputed payment and PPS rate.
Delegating to MCOs full responsibility for paying the FQHC its PPS (or APM) rate causes conflict of interest on part of MCO.

- Inconsistent with intent of BBA 1997. That law did two things:
  1. Changed MCOs’ payment obligation from 100% to “not less than” amount paid to non-FQHCs. Purpose – remove financial disincentive to contract with FQHCs.
  2. Required states to make a “supplemental payment to FQHCs” equal to difference.

- CMS interpretation – that law prohibits “state’s” delegation of payment obligation – is entitled to deference.

- State must have contract with MCO that incorporates MCO’s “not less than” payment obligation. Purpose: enforcement and pay-and-chase burden on states, not FQHCs.

State may delegate wraparound if done through an APM that center negotiates and agrees to, but that should be done only if appropriate protections are built-in to ensure full and timely payments.
Offsetting all MCO payments from wraparound, regardless of whether the payments correspond to FQHC services. Examples:

- State-MCO contract allows MCOs to require FQHCs to enter into risk-based capitation contracts with the MCO, under which the FQHC assumes risk for services beyond the scope of the services the FQHC provides directly. The state then counts total capitation payments paid by the MCO to the FQHC—including the amounts the FQHC is obligated to pay to other providers under the risk-based contract—against the wraparound payment.

- MCO offers incentive payments to network providers to encourage cost containment or attainment of quality benchmarks. Per CMS guidance, MCO incentive payments cannot be used to offset state’s calculation of its Medicaid wraparound.

WRAPAROUND ISSUE-SPOTTING

- What to look for:
  - **Visit count** – is it accurate? Does state count all managed care visits in reconciliation? Does it exclude unpaid MCO claims? What data is being used to count visits? Does state impute payments not actually received?
  - **Timing issues** – does state pay fully supplemental payments at least every four months?

- **Bottom line** – does supplemental payment system:
  - make fully compensatory payments (difference between actual payment received and amount owed)
  - on a timely basis (at least every four months)
  - Does state provide for a timely annual reconciliation to ensure accuracy of supplemental payments?
Alternative Payment Methodologies

ALTERNATIVE PAYMENT METHODOLOGIES

(APM)

Social Security Act § 1902(bb)(6) allows a State to implement a payment method that acts as an alternative to PPS but only if:

1) the APM is described in the State plan,
2) the APM pays at least equal to the PPS, and
3) each health center consents to the arrangement.
   - It is worth noting that APM payment amounts must be reasonable, documented, etc., but the payments can be higher than the PPS and the State still receives federal financial participation
   - Over 20 States have some form of an APM
APMS – CONTENTIOUS ISSUES

• Failing to ensure that FQHCs are paid at least PPS
  – Failing to keep PPS rates “current” (*i.e.*, adjusted for inflation and CIS) to make this calculation valid
  – No annual comparison of PPS to APM
• Reverting to PPS rates that have never been adjusted for CIS
• Deviating from the State plan’s description of APM
  – All issues with setting and limiting a cost based rate if that is APM
  – crucial question: what does State Plan require?
• Delay in reconciling cost reports (many states’ APMs are based on reasonable cost methodology)
• Never obtaining FQHC consent to APM
• Making all FQHCs agree to APM before State will implement

QUESTIONS?

THERE ARE SEVEN DAYS IN THE WEEK AND SOMEDAY ISN'T ONE OF THEM.
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CONTACT INFORMATION

Edward “Ted” Waters, Esq.
Ewaters@ftlf.com

Feldesman Tucker Leifer Fidell LLP
1129 20th Street N.W. – Suite 400
Washington, D.C. 20036
(202) 466-8960
www.ftlf.com