



NATIONAL ASSOCIATION OF
Community Health Centers



***Emerging Issues in the FQHC Prospective
Payment System***

September 2011

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**State Policy Report #38:
Emerging Issues in the FQHC Prospective Payment System**

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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.

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.

This publication was supported by Grant/Cooperative Agreement Number U30CS16089 from the Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA/BPHC.

INTRODUCTION

In January and February 2011, the National Association of Community Health Centers sponsored a series of conference calls for Primary Care Associations to discuss various issues with the Medicaid prospective payment system (“PPS”) used to reimburse FQHCs under Medicaid and options for addressing these issues. This report (1) provides an overview of the FQHC payment provisions; (2) discusses various State practices that may result in inadequate payment levels and (3) summarizes several federal court cases in which health centers sued State Medicaid agencies to address inadequate rates. The federal PPS statute can be found in the Appendix on pages 15-16.

BACKGROUND ON FQHC PAYMENT PROVISIONS

The Medicaid program

In 1965, the Medicaid program was established with the passage of Title XIX of the Social Security Act.¹ Activities under the program are carried out by states. By engaging the services of hospitals, clinics, physicians, and other providers, a State’s Medicaid agency makes health care available to the program beneficiaries. State participation in the Medicaid program is voluntary, but once a State elects to do so it must comply with all federal requirements. The States receive federal funds (referred to in the Medicaid statute as Federal Medical Assistance Payments (“FMAP”)) to cover a percentage (a minimum of 50 percent) of the State’s expenses for the Medicaid program.

Any State that has elected to participate in the Medicaid program must submit, for prior federal approval, a Medicaid State Plan. The Plan contains provisions regarding eligibility conditions, medical care and services, payment, and compliance with program requirements. The Secretary of the U.S. Department of Health and Human Services (“HHS”) reviews each plan to assure that it complies with federal statutory and regulatory requirements. The Secretary has delegated the power to review and approve plans to Regional Administrators of the Centers for Medicare and Medicaid Services (“CMS”), the division of HHS responsible for the Medicaid program.

The role of health centers as safety net providers

For over thirty-five years, health centers receiving grants under Section 330 of the Public Health Service Act and related “look-alike” health centers have provided primary and preventive health care services to “medically underserved” populations or areas without regard to a patient’s ability to pay.² In addition to receiving direct grants³, health centers have been reimbursed for providing Medicare and Medicaid services.⁴

¹ Codified at 42 U.S.C. § 1396 *et seq.*

² 42 U.S.C. §§ 254b and 1396d(1)(2)(B); 42 C.F.R. § 51c.102(e).

Over time, Congress became increasingly concerned that Section 330 grant funds were being used to subsidize the costs of serving Medicare and Medicaid beneficiaries because those programs were not paying adequately.

FQHC Medicaid services and reimbursement

In 1989, Congress established⁵ in the Social Security Act a new provider type – “Federally-qualified health center” or “FQHC.”⁶ FQHCs are public or tax-exempt entities which receive a direct grant from the United States under Section 330 of the Public Health Service Act, or are determined by HHS to meet the requirements for receiving such grants. Certain outpatient clinics that target Native American populations also qualify as FQHCs. This statute defined the services to be provided by FQHCs for Medicaid purposes and included special payment provisions to ensure that they would be reimbursed for 100 percent of their reasonable costs associated with furnishing these services. As indicated in the Congressional Record, one of the express legislative purposes in doing so was to “ensure that Federal [Public Health Service] Act grant funds are not used to subsidize health center or program services to Medicaid beneficiaries.”⁷

A State Medicaid plan must pay for covered services provided by FQHCs. These covered services include “Federally-qualified health center services”⁸ and “any other ambulatory

³ Look-Alike health centers do not receive grant funds under Section 330, but meet all the program requirements to receive them.

⁴ In 2010, 38.5% of health center patients had Medicaid coverage. An exact number of health center patients enrolled in Medicare is not currently available, but data shows that 6.8% of health center patients were age 65 or older in 2010. Uniform Data System Report, Health Resources and Services Administration, U.S. Health and Human Services Agency (2010), *available at* <http://bphc.hrsa.gov/uds/view.aspx?year=2010>.

⁵ Omnibus Budget Reconciliation Act, Pub. L. No. 101-239.

⁶ 42 U.S.C. § 1396d(l)(2); 42 U.S.C. § 254b.

⁷ H.R. Rep. No. 101-247, at 392-93, reprinted in 1989 U.S.C.C.A.N. 2118-19. The 1989 legislation did not mention Congress’s concern with a Medicare subsidy at the time because the FQHC benefit (and related payment provision) was not added to Medicare until 1990, the following year.

⁸ Medicaid defines “Federally qualified health center services” as “services of the type described in subparagraphs (A) through (C) of section 1395x (aa)(1) of [the Medicare statute] when furnished to an individual as an [sic] patient of a Federally-qualified health center.” 42 U.S.C. § 1396d(l)(2)(A). Subparagraphs (A) through (C) of section 1395x(aa)(1) include: (1) “physicians’ services” and services furnished as an “incident to” a physician’s professional service; (2) services furnished by a physician assistant, nurse practitioner, clinical psychologist, clinical social worker; and (3) “in the case of a rural health clinic located in an area in which there exists a shortage of home health agencies, part-time or intermittent nursing care and related medical supplies (other than drugs and biologicals) furnished by a registered professional nurse or licensed practical nurse to a homebound individual under a written plan of treatment (i) established and periodically reviewed by a physician described in paragraph (2)(B), or (ii)

services offered by a federally qualified health center and which are otherwise included in the [State] plan.” From 1989 until 2000, the FQHC Medicaid payment system was based on per-visit payment rates and retroactive adjustments. That is, each FQHC received a provisional per-visit rate premised on the prior year’s rate and an annual reconciliation, similar to Medicare. After the year ended, the cost reports for that year were reconciled, and the level of overall payments was adjusted retroactively as necessary. This approach was cumbersome and time-consuming.

In December 2000, Congress required states to change their FQHC payment methodology from a retrospective to a prospective payment system (“PPS”).⁹ This law established (for existing FQHCs) a per-visit baseline payment rate equal to 100 percent of the center’s average costs per visit incurred during 1999 and 2000 which were reasonable and related to the cost of furnishing such services.¹⁰ The general formula for establishing a PPS rate was to take the average of the total reasonable costs for 1999/2000 and divide by the average of the total visits for those years (*i.e.*, total costs / total visits = PPS rate).

Since January 1, 2001, states have been required to pay FQHCs a per-visit rate, which is equal to the baseline PPS payment rate increased each year by a standard medical inflation factor, known as the Medicare Economic Index (“MEI”), and adjusted “to take into account any increase or decrease in the scope of such services furnished by the center . . . during that fiscal year.”¹¹

Thus, under PPS, State Medicaid agencies are required to pay centers their PPS per-visit rate (or an alternative payment methodology (APM)) for each face-to-face encounter between a Medicaid beneficiary and one of the center’s billable providers for a medically necessary (and covered) service, regardless of the actual cost to the FQHC of providing that visit or the number of services performed at the visit.¹²

The PPS rate is a floor, not a ceiling, on reimbursement for FQHC services. No Federal law prevents a State from paying FQHCs above the PPS rate. Congress explicitly allows states to use an Alternative Payment Methodology (APM) so long as it “results in payment to the center or clinic of an amount which is at least equal to the amounts otherwise required to be paid to the center or clinic” under PPS, and the FQHC agrees to it.¹³ In 2010, approximately 21 states used an APM to pay some or all of their FQHCs.

established by a nurse practitioner or physician assistant and periodically reviewed and approved by a physician . . .” 42 U.S.C. § 1395x(aa)(1)(A) – (C).

⁹ Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (“BIPA”), codified at 42 U.S.C. § 1396a(bb).

¹⁰ 42 U.S.C. § 1396a(bb)(1)-(5).

¹¹ *Id.* at § 1396a(bb)(3)(B).

¹² *Id.* at § 1396a(bb)(1).

¹³ *Id.* at § 1396a(bb)(6)(B).

STATE POLICIES WHICH MAY RESULT IN INADEQUATE FQHC PPS PAYMENTS

Miscalculation of baseline rates through use of cost ceilings

In calculating a center's PPS rate, states often impose ceilings (*i.e.*, limits) on allowable cost categories. As explained above, states are required under PPS to establish a per-visit baseline payment rate equal to 100 percent of the center's average costs incurred during the base years (1999 and 2000) which are reasonable and related to the cost of furnishing covered services.¹⁴ A cost ceiling is not allowed if it effectively excludes reasonable and related costs from the rate computation¹⁵ and thereby decreases the per-visit rate without any prior determination as to whether the *above*-ceiling cost is in fact *unreasonable* (unallowable).

Where a baseline PPS rate is improperly calculated at the outset, it remains flawed for all future years, even when adjusted for inflation or a change in scope. It is the perpetual nature of this flaw that enables health centers to challenge a PPS rate years after the original calculation, which is what health centers did in the following case.

Maryland FQHCs successfully challenged rate ceilings

In *Chase Brexton Health Services, et al v. Maryland* (D.Md. 2006), seven health centers filed a federal lawsuit against the State of Maryland alleging that its method of reimbursement violated the FQHC Medicaid payment provisions. In particular, the centers asserted that the State had imposed an administrative cap and a rate ceiling on primary care services without first determining whether those payment limitations were "reasonable" – *i.e.*, would still compensate FQHCs for 100 percent of "reasonable" costs of caring for Medicaid patients, as required by federal law.

Maryland had originally adopted these two cost limits in 1991. Many years later, in 2001, CMS approved the State's use of the two cost limits as part of a State Plan Amendment that Maryland had submitted to comply with BIPA 2000. On remand, the federal district court rejected Maryland's arguments on the ground that its payment methodology had no rational basis and did not address the specific circumstances of the FQHC under reconsideration. As a result of the Court's ruling in 2006, the State had to re-calculate PPS rates for each plaintiff health center without the application of the two cost limits.

Use of caps based on "peer groups"

Another State uses cost-ceilings to reduce payments to which health centers are entitled. The State applied ceilings on "operating costs" – which include administrative costs

¹⁴ *Id.* § 1396a(bb)(1)-(5).

¹⁵ As cost is excluded from the numerator (total costs / total visits = PPS rate), the per-visit rate decreases.

(e.g., health care personnel salaries – the biggest cost), transportation costs, and patient care costs (e.g., costs associated with the provision of ancillary, medical, dental, and therapy services) – based on an average of such costs within “peer-groups.” The peer groups consisted of FQHCs grouped by geographic region. The State did not consider any then-current economic data to support its peer groupings. Instead, it established the FQHC peer groups based on regional economic data, such as wage data, that was outdated (e.g., a 1980 U.S. Census report). For each peer group, the ceilings were computed at 105 percent of the average of the base year (1999 – 2000) costs of the centers in the group.

The per-visit rate the state computed for each FQHC reflected the *lower of* (a) each center’s actual allowable operating cost per visit, or (b) the peer group ceiling on operating cost per visit, plus (in either scenario) an allowable capital cost per visit.

This payment methodology not only uses outdated data and averaging among not necessarily identically situated centers, but it also (like the methodology rejected in *Chase Brexton*) excludes any cost that exceeds the peer group ceiling, without any analysis of each center’s circumstances.

Adoption of Medicare FQHC Payment Methodology, including Productivity Screens and Rates

Instead of examining an individual center’s costs from 1999 and 2000 and applying cost-principles to identify reasonable costs, some states simply adopt the Medicare program’s payment system, including its cap (*i.e.*, upper payment limit) and/or screen (productivity screen),¹⁶ and pay the *Medicare* per-visit rate as if it were the *Medicaid* PPS rate. To comply with federal law, the baseline PPS rate must account for 100 percent of each center’s reasonable costs in 1999/2000 to furnish *all* Medicaid covered services.¹⁷ One issue with adopting the Medicare method, without any modification or adjustment, is that Medicare covers a narrower set of services than Medicaid. As a result, a Medicare cost report, and the resulting per-visit rate will not capture the higher cost and broader range of Medicaid services that FQHCs are required to provide.¹⁸ In addition, Medicare rates are subject to Upper Payment Limits, which function as a rate ceiling.¹⁹

¹⁶ A productivity screen is a number representing the number of visits a provider should have in any given time period, usually a year. If a provider has fewer visits, then the State pays less. For example, if the productivity screen is set at 100 visits and a provider has only 90 visits, then the State would pay only 90% of the costs of those visits. See *Community Health Center, Inc. v. Wilson-Coker*, 175 F. Supp. 2d 332 (D. Conn. 2001).

¹⁷ The Medicaid statute does not expressly authorize or impose any caps on those costs. Instead, the Medicaid statute permits the use of “tests of reasonableness as the Secretary prescribes in [Medicare] regulations,” 42 U.S.C. § 1396a(bb), but that reference is to the cost principles articulated in Medicare regulations, not to the use of caps and screens.

¹⁸ The U.S. Government Accountability Office (“GAO”) identified this potential issue in a 2005 report evaluating the states’ implementation of BIPA PPS for FQHCs and Rural Health Clinics. The GAO stated:

In a 1995 letter to State Medicaid Directors, CMS condoned²⁰ the states' use of the Medicare method, including caps and screens, if a critical proviso is met.²¹ In particular, CMS has said that states may "use their own tests of efficiency and economy" – including the "Medicare FQHC payment system and its cost containment mechanisms (*e.g.*, payment caps and productivity screens)" – as the basis for FQHC Medicaid payment, "as long as the State determines and assures HCFA that it covers the FQHC's reasonable cost for both core and other ambulatory services." If the State "plans to use the Medicare system *exclusively*, a determination would have to be made on whether adjustments to the Medicare [cap] are needed to account for the costs incurred in furnishing other ambulatory services."²²

In other words, if a State chooses to use the Medicare payment system, with its caps and screens, CMS has required such a State, through studies, analysis, or the like, to be certain that such caps are set high enough to ensure that all FQHCs will be paid 100 percent of their costs which are "reasonable and related to the cost of furnishing such services."²³ In past experience, we have found the absence of any study or analysis by States to determine whether costs being excluded by the Medicare limits (and therefore not reimbursed) were "reasonable and related to the cost of furnishing such services."

This issue was addressed in the case of *Connecticut Primary Care Ass'n. Inc. v. Wilson-Coker*, Civ. No. 02-626, 2006 WL 2583083 (D. Conn. Sept. 5, 2006.) After BIPA 2000 established the PPS payment methodology for FQHCs, Connecticut submitted a revised State Plan that, among other things, sought to continue the State's use of a productivity standard for FQHC physicians that had been part of the State's FQHC reimbursement formula since 1996. The productivity standard – which is premised on a federal Medicare regulation issued in 1992 – reduced FQHC payments to the extent that the FQHC's physicians had fewer than 4,200 patient visits per year. CMS approved the State Plan in June 2001.

BIPA PPS rates in more than one-third of states may be inappropriate – these states reported that their rates did not include all Medicaid-covered FQHC and RHC services. These states most commonly excluded laboratory, radiology, and dental services. These exclusions are inappropriate because, under BIPA and CMS guidance, the BIPA PPS must include all Medicaid-covered services – specifically, outpatient services provided in an FQHC or RHC and included in the state's plan. Prescription drugs are the one service that states are allowed to exclude from the BIPA PPS rate, according to CMS. Thus, all other Medicaid-covered outpatient services provided by an FQHC or RHC must be paid for under the BIPA PPS.

¹⁹ The Government Accounting Office found that in 2007, 72% of FQHCs had costs that exceeded the upper payment limit. See <http://www.gao.gov/mobile/products/GAO-10-576R>

²⁰ Sally K. Richardson, Medicaid Director Letter, May 8, 1995.

²¹ *Community Health Center v. Wilson-Coker*, 311 F. 3d 132 (2d Cir. 2002).

²² Sally K. Richardson, Medicaid Director Letter, May 8, 1995.

²³ 42 U.S.C. § 1396a(bb)(2).

Shortly thereafter, a Connecticut health center sued the State and challenged its FQHC payment methodology. In November 2001, the federal district court concluded that the 1992 federal Medicare regulation had been improperly promulgated. In turn, the court concluded that the Connecticut's Medicaid FQHC payment formula was invalid because it had incorporated the defective regulation's productivity standard.²⁴

In 2002, the Second Circuit Court of Appeals set aside the district court's decision because the dispute required a determination of the lawfulness of a Medicare regulation. Participating as an amicus, CMS expressed the position it had articulated in the Medicaid Directors letter dated May 8, 1995. The Second Circuit embraced the substance of the CMS letter and concluded that the central issue is whether Connecticut's reliance on a productivity screen resulted in payment based on 100 percent of the FQHC's reasonable and related costs in providing Medicaid services.²⁵

The case was remanded to the district court to resolve that question. On remand, the Connecticut Primary Care Association joined the case on behalf of its members. Through discovery, the PCA established that neither the State nor HCFA had documented any basis for the screen, other than the fact that the Bureau of Primary Health Care had at one time (long since past) used it.

Having found that Connecticut could not rely on CMS's approval of its State Plan, the district court decided that Connecticut's use of the productivity standard violated the requirement in the Medicaid statute that an FQHC be reimbursed "in an amount . . . equal to 100 percent of the average of the costs of the center or clinic in furnishing such services . . . which are reasonable and related to the cost of furnishing such services . . ." ²⁶ As a result, the State could not use the 4,200 visit screen when calculating PPS base rates.

Visit Limits

Many states impose limits on the number of visits for which an FQHC may submit a claim to Medicaid at its per-visit rate. For example, some states limit claims to: one billable visit per day; one medical, one behavioral, and one dental visit per day; a maximum number of visits per year; or, a maximum cost of a particular type of service (*e.g.*, dental) per year.²⁷

The Medicaid Director Letter and the *Connecticut Primary Care* decision discussed above provide the standard by which a payment limit must be measured. That is, in order to use a visit limit a State must show that it conducted a study or analysis to determine whether costs

²⁴ *Community Health Center, Inc. v. Wilson-Coker*, 175 F. Supp. 2d 332 (D. Conn. 2001).

²⁵ *Community Health Center v. Wilson-Coker*, 311 F. 3d 132 (2d Cir. 2002).

²⁶ *Connecticut Primary Care Assoc. v. Wilson-Coker*, 2006 WL 2583083 (D. Conn. 2006)

²⁷ See *2009 Update on the Status of the Medicaid and CHIP Prospective Payment System in the States*, Dawn McKinney *et al.*, (Sept 2009).

being excluded by the visit limit (and therefore not reimbursed) were not “reasonable and related to the cost of furnishing such services.”²⁸

Carve outs or services paid at less than PPS requires

Some states carve out specific mandatory FQHC services and pay them using a different payment methodology. In some cases these carve-outs may violate the federal requirement that a PPS per-visit rate be based on 100 percent of the center’s reasonable costs.²⁹

For example, some states carve out prenatal care and pay a global rate for a certain scope of prenatal services. In some cases, the net payments received by a center for all services provided (within the scope of covered services) equal less than what the center would be paid if it simply charged its PPS per visit rate for each prenatal encounter.

Another example is the carve out of so-called offsite services – *i.e.*, services provided by an FQHC provider at a location other than the center. CMS has said in correspondence that the OBRA 1990 amendments – which replaced the word “outpatient” with “patient” in the definition of FQHC services – make clear that “Congress intended States to reimburse for FQHC services when provided off-site.” An analysis of a particular state’s rules on offsite services may be needed. Some states pay for these services at a rate less than PPS. The states must pay FQHCs under PPS for Medicaid-covered FQHC services regardless of whether the service is rendered on or offsite. If the particular service would have generated a billable visit at the center, it would generate a billable visit offsite.³⁰

Change in scope of services

Some states have not implemented a methodology to account for changes in scope of services for fiscal year 2002 or any subsequent year. As a result, health centers which have added or expanded their scope of services without any rate adjustment to account for cost increases are not getting reimbursed as required.

Because the PPS system sets rates based on historical costs of providing Medicaid services in 1999 and 2000, the Medicaid statute requires states to adjust the rate for two reasons: (1) inflation and (2) “to take into account any increase or decrease in the scope of such services furnished by the center . . . during that fiscal year.” To comply with the latter requirement, states must do two things: (1) define a qualifying event for a scope change; and (2) set out a methodology for computing the change in rate.

²⁸ 42 U.S.C. § 1396a(bb)(2).

²⁹ *Id.* at § 1396a(bb)(1).

³⁰ This assumes that the cost of the service was accounted for in the base years of the center’s PPS rate. If not, a change in scope rate adjustment may be needed.

CMS has stated that a “state must develop a process necessary for determining a change in scope of services,” and a change in scope “shall occur if” the center “has added or has dropped any service that meets the definition of FQHC services . . . [or] the service is included as a covered Medicaid service under the Medicaid state plan approved by the Secretary.”³¹ Apart from adding or dropping covered services, CMS has not specified what constitutes a change in scope of services, but has said that it means “a change in the type, intensity, duration and/or amount of services.”³²

Deficiencies and delays in wraparound

State Medicaid agencies must make “wraparound” payments to FQHCs to cover the difference, if any, between what an FQHC has been paid by the Managed Care Organizations (MCOs) and the center’s PPS or APM per-visit rate.³³ States are required to make the wraparound payments at least every four months. In Section 4712 of the BBA of 1997, Congress did two things. First, it relieved the MCO of the responsibility to pay the FQHCs their cost-based rate and instead required the MCOs to pay FQHCs “not less” than they would pay non-FQHC providers for the same medical services.³⁴ Second, it ensured that FQHCs were reimbursed the amounts required by federal law by requiring States to make a direct “supplemental payment [to FQHCs] equal to the amount . . . by which” an FQHC’s reasonable costs “exceed[ed] the amount of payments” FQHCs received from MCOs.³⁵ In doing so, “Congress intended to encourage contracting between [FQHCs] and MCOs and to remove financial barriers to this contracting.”³⁶

Visits that do not generate MCO payments not included in calculation of wraparound rate

One State pays wraparound claims using a “proxy” wraparound rate. The proxy is an estimate of the difference between an MCO payment and a center’s PPS rate.

In particular, the State calculates a center’s average per-visit MCO payment and subtracts that amount from the center’s PPS rate to arrive at the center’s proxy wraparound rate.

$$\begin{array}{r} \text{PPS Rate} \\ - \text{Average MCO payment} \\ \hline = \text{Proxy wraparound rate} \end{array}$$

³¹ Letter dated Sept. 12, 2001 from HCFA to Medicaid Regional Administrators with “Q’s and A’s” on BIPA/PPS implementation.

³² *Id.*

³³ 42 U.S.C. § 1396a(bb)(5)(B).

³⁴ 42 U.S.C. § 1396(m)(2)(A)(ix) (1997).

³⁵ *Id.* at § 1396a(a)(13)(C) (1999).

³⁶ *See supra* n. 34.

In calculating the center's average MCO payment, the State excludes visits for which the center was *not* paid by the MCO. The effect of the exclusion is to artificially increase the average MCO payment, by decreasing the total number of visits by which the total MCO payment is divided. Under the State's formula, the proxy wraparound rate decreases as the average MCO rate increases (by excluding unpaid claims), resulting in lower wraparound payments to the FQHC. Beyond cash flow problems created by insufficient proxy rates, the problem can be exacerbated by a lack of reconciliation (to determine the difference between the total amount of managed care payments received by the center and total amounts owed by the State).

Paid claim policy

A few states have a "paid claims" policy pursuant to which health centers cannot submit a wraparound claim for a visit *unless and until* it has received payment from the MCO. This can result in delays in FQHCs receiving payments, and these can extend beyond the 120 day turnaround required in the statute. In addition, this can result in the FQHC receiving no payment from either the MCO or the state for some services. However, the statute states that the obligation to make fully compensatory payments to FQHCs rests with the State, not the MCOs.³⁷ If an MCO fails to make payment for a billable FQHC service to a Medicaid beneficiary, the State's "wraparound" obligation is the full PPS payment amount (*i.e.*, 100 percent of the difference between the MCO payment and the PPS rate). The only permissible reduction of a State's PPS payment obligation is for an *actual* MCO payment³⁸.

If MCOs are not paying legitimate FQHC managed care claims for whatever reason, the burden rests with the State, not the FQHCs, to address the problem. Congress confirmed this point when it amended the Medicaid managed care provisions to prohibit the federal approval required for all MCO contracts unless the contract includes a provision that obligates the MCO to "provide [FQHCs] payments that [are] not less than the level and amount of payment . . . the [MCO] would make if the services were furnished by a provider which is not [an FQHC]."^{39, 40}

³⁷ 42 U.S.C. § 1396a(bb)(5)(A).

³⁸ This section does not address the so-called "out of network" services. If a patient is out of network (*i.e.*, enrolled in an MCO with which the FQHC does not have a provider agreement) and receives medically necessary care that is "immediately required due to an unforeseen illness, injury or condition," 42 U.S.C. § 1396b(m)(2)(A)(vii), the MCO's contract with the state must indicate whether the MCO has a payment obligation to the FQHC, or whether the payment obligation rests with the state.

³⁹ 42 U.S.C. § 1396b(m)(2)(A)(ix).

⁴⁰ This position is consistent with statements made by CMS in the context of MCO insolvency. See Timothy M. Westmoreland, CMS, State Medicaid Director Letter, Policy Regarding FQHCs/RHCs (Sept. 27, 2000) Medicaid (available at <https://www.cms.gov/smdl/downloads/smd092700.pdf>) (last visited Oct. 19, 2010) ("In order to ensure that FQHCs/RHCs are paid reasonable costs under the Act, the State is required to include, as part of supplemental payments, monies that FQHCs/RHCs subcontracted to receive but did not receive from an insolvent MCO. HCFA will provide FFP for the State's payment.

State delegation of supplemental payment obligation to MCOs

Some states have attempted to delegate the State's obligation to make wraparound payments to MCOs, thereby subjecting health centers to the MCOs' cost-containment strategies. CMS, however, has interpreted amendments in the Balanced Budget Act of 1997⁴¹ as prohibiting such a delegation because the statute specifically requires a *State*, not an MCO, to make the wraparound payment.⁴²

Bundling requirements

Some States have established rules or policies after centers' PPS calculation was originally made that requires a center to combine services which previously qualified as multiple billable visits into a single visit. These policies have the effect of increasing a center's per-visit cost and decreasing its visits, without any rate adjustment. If a center's rate had originally been premised on the two discrete services being done together, the center's 1999/2000 baseline PPS rate would have been higher from the outset.

For example, in one state, health centers were scheduling dental examinations and cleanings on different days and billing for each visit as a separate threshold visit in 1999 and 2000. Doing so was largely a function of: (1) the needs of its "medically underserved" patient population (*e.g.*, cleanings are often time-intensive procedures for its patients) and; (2) its understanding that separate visits for an exam and a prophylaxis cleaning (which involve two different services from two different types of licensed providers – a dentist and a hygienist) was and is consistent with the standard of care. For each center that provided dental services, its PPS rate was premised on the fact that it provided these distinct services at separate visits. Several years after the centers' PPS rates were calculated the state implemented a policy requiring the centers to bundle these services into one visit. In doing so, the centers' per-visit costs increased and their total number of visits decreased without any adjustment to the rate. If each center's original rate had been calculated premised on the two services being done together, the center's baseline PPS rate would have been higher.

Invalid eligibility criteria to participate in (and bill) Medicaid

Some states are using a Medicare regulation (42 C.F.R. § 491.5(a)(3)(iii)) as basis to require that each of a center's sites be separately approved by and have a separate Medicaid provider number as prerequisite to billing Medicaid. State agencies are seeking to recoup all

Ultimately, the State, on behalf of the FQHC/RHC, is eligible to receive any settlement funds that the FQHC/RHC recovers through bankruptcy proceedings.”).

⁴¹ Codified at 42 U.S.C. 1396b(m)(2)(A)(ix)).

⁴² Sally K. Richardson, Medicaid Director Letter, April 20, 1998 (“Congress intended to encourage contracting between FQHCs/RHCs and MCOs and to remove financial barriers to this contracting”).

payments received for Medicaid services rendered at a site that has not satisfied those “criteria,” even if the site is within the center’s approved Section 330 scope of project.

The Medicare regulation says that a FQHC must obtain prior site-specific approval from the CMS to qualify for FQHC reimbursement for *Medicare* services rendered at each of its permanent service sites.⁴³ However, the regulation does not apply to FQHC reimbursement under the *Medicaid* program. There is no federal requirement for an FQHC to secure separate Medicaid enrollment of each of its service sites.⁴⁴

Deficiencies in rate-setting for new start centers

Federal law requires, for the purposes of determining the PPS rate of a new health center, that the State look to a health center or centers that (1) are in the same or adjacent areas, and (2) possess a similar caseload.⁴⁵ If both of those criteria cannot be met, then the State must use a cost-based methodology.⁴⁶ A number of States have devised rate-setting methods for new starts that do not comply with these requirements with the result that new starts may have received rates that are deficient and less than what federal law requires.

For example, in *United Family Practice Health Center, Inc. v. Minnesota Dep’t of Human Services*, Civ. No. 06-959 (D. Minn.), a new look-alike FQHC sued the Minnesota Medicaid agency after being assigned a PPS rate that it viewed as unduly restrictive. When calculating the center’s rate, Minnesota refused to use center rates from the same or adjacent area with a similar caseload. The state’s rationale was that the nearby centers had dental services and the new center did not plan to provide dental services, even though the centers were otherwise very similar and dental costs could have been easily removed to calculate a rate. The State ultimately decided to use a caseload comparison method that looked at centers beyond adjacent areas even though the statute only authorizes comparison to centers in the same or adjacent areas. That method resulted in a rate that was below the new center’s actual costs of providing Medicaid covered services and not equivalent to more comparable health centers closer by.

⁴³ *Id.* at §§ 491.1, 491.5(a)(3)(iii).

⁴⁴ *Cf. Intercommunity Medical Center v. Belshe*, 32 Cal. App.4th 1708, 1711, 39 Cal. Rptr.2d 43 (1995) (“Medicare guidelines are not generally applicable to the Medi-Cal program”) (citing *Mission Community Hospital v. Kizer*, 13 Cal. App.4th 1683, 1689-90, 17 Cal. Rptr.2d 303 (1993)). FQHC status, and the State’s FQHC payment obligation, extends to all service sites approved under the health center’s Section 330 grant. 42 U.S.C. § 1396a(bb); State Medicaid Manual § 4231 (a recipient of a § 330 grant “automatically qualified for provision of and payment for [Medicaid FQHC] services . . .”).

⁴⁵ 42 U.S.C. § 1396a(bb)(4).

⁴⁶ *Id.*

The health center's lawsuit sought: (1) a declaration that the State's PPS methodology, including its "caseload comparison survey" process, was arbitrary, capricious, and violative of federal law, and (2) an injunction prohibiting the State from using its PPS methodology to make future payments to the center. The center also filed a State administrative action in order to recover retroactive amounts representing the difference between the rate the State assigned and the rate the center believed it should have been assigned. Following discovery in the federal litigation (including the depositions of several State officials), the State and the health center were able to agree as to the terms of a settlement agreement. Pursuant to that agreement, the health center was assigned a PPS rate that the center found acceptable, and this rate was established retroactively, ensuring that payment would be made to the health center based on the new rate for services already provided.

CONCLUSION

Primary Care Associations and their health center members should continue to monitor FQHC payments under Medicaid. Fortunately there exists a favorable body of case law that can be used – through rulemakings, informal negotiation with the Medicaid agency, or litigation – to safeguard FQHC reimbursement. If analysis of current PPS rates and practices has not already been conducted by PCAs and health centers at the state and local level, now is the time to do it. In 2014, with the expansion of Medicaid and the start of health insurance exchanges, a properly calculated PPS rate will be crucial to health centers. In order to assist in that process, a series of PPS best practice reports are currently under development.

APPENDIX

Section 1902 of the Social Security Act

(bb) Payment for Services Provided by Federally-Qualified Health Centers and Rural Health Clinics.—

(1) In general.—Beginning with fiscal year 2001 with respect to services furnished on or after January 1, 2001, and each succeeding fiscal year, the State plan shall provide for payment for services described in section [1905\(a\)\(2\)\(C\)](#) furnished by a Federally-qualified health center and services described in section [1905\(a\)\(2\)\(B\)](#) furnished by a rural health clinic in accordance with the provisions of this subsection.

(2) Fiscal year 2001.—Subject to paragraph (4), for services furnished on and after January 1, 2001, during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is 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 regulations under section [1833\(a\)\(3\)](#), or, in the case of services to which such regulations do not apply, the same methodology used under section [1833\(a\)\(3\)](#), 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.

(3) Fiscal year 2002 and succeeding fiscal years.—Subject to paragraph (4), for services furnished during fiscal year 2002 or a succeeding fiscal year, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for such services under this subsection for the preceding fiscal year—

(A) increased by the percentage increase in the MEI (as defined in section [1842\(i\)\(3\)](#)) applicable to primary care services (as defined in section [1842\(i\)\(4\)](#)) for that fiscal year; and

(B) adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during that fiscal year.

(4) Establishment of initial year payment amount for new centers or clinics.—In any case in which an entity first qualifies as a Federally-qualified health center or rural health clinic after fiscal year 2000, the State plan shall provide for payment for services described in section [1905\(a\)\(2\)\(C\)](#) furnished by the center or services described in section [1905\(a\)\(2\)\(B\)](#) furnished by the clinic in the first fiscal year in which the center or clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100

percent of the costs of furnishing such services during such fiscal year based on the rates established under this subsection for the fiscal year for other such centers or clinics 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) or based on such other tests of reasonableness as the Secretary may specify. For each fiscal year following the fiscal year in which the entity first qualifies as a Federally-qualified health center or rural health clinic, the State plan shall provide for the payment amount to be calculated in accordance with paragraph (3).

(5) Administration in the case of managed care.—

(A) In general.—In the case of services furnished by a Federally-qualified health center or rural health clinic pursuant to a contract between the center or clinic and a managed care entity (as defined in section [1932\(a\)\(1\)\(B\)](#)), the State plan shall provide for payment to the center or clinic by the State of a supplemental payment equal to the amount (if any) by which the amount determined under paragraphs (2), (3), and (4) of this subsection exceeds the amount of the payments provided under the contract.

(B) Payment schedule.—The supplemental payment required under subparagraph (A) shall be made pursuant to a payment schedule agreed to by the State and the Federally-qualified health center or rural health clinic, but in no case less frequently than every 4 months.

(6) Alternative payment methodologies.—Notwithstanding any other provision of this section, the State plan may provide for payment in any fiscal year to a Federally-qualified health center for services described in section [1905\(a\)\(2\)\(C\)](#) or to a rural health clinic for services described in section [1905\(a\)\(2\)\(B\)](#) in an amount which is determined under an alternative payment methodology that—

(A) is agreed to by the State and the center or clinic; and

(B) results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under this section.