Federally Qualified Health Center and Rural Health Clinic Alternative Payment Methodology

Purchasing and Service Delivery
April 1, 2016

For more information contact:

Minnesota Department of Human Services
Health Care Administration
P.O. Box 69083
St. Paul, MN 55164-0983
(651) 431-2106

Minnesota Department of **Human Services**

Legislative Report

This information is available in accessible formats to individuals with disabilities by calling 651-431-2670 or 800-657-3739

Or by using your preferred relay service.

For other information on disability rights and protections, contact the agency's ADA coordinator.

Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $5000.00.

Printed with a minimum of 10 percent post-consumer material. Please recycle.

Legislative Report

Minnesota Department of **Human Services**

Table of Contents

I. Executive summary

The 2015 Legislature requested a recommendation for a new alternative payment methodology (APM) for federally qualified health centers (FQHC) and rural health clinics (RHC) that covers the cost of all Medical Assistance (MA) services. The Department of Human Services (DHS), Minnesota Association of Community Health Clinics (MNACHC) and FQHC providers believe that the current prospective payment system methodology does not adequately reflect the current health care cost trends and results in payment rates that may not accurately reflect a clinic's costs.

In consultation with MNACHC and FQHC providers, DHS developed this report which details the recommendation for a new APM rate structure which could be adopted upon enabling legislation. Recommendations are provided for both a general APM structure as well as methodology details including: options for rebasing; base years; effective date; base year and bi-annual inflators; quality measures; retention/deletion of current alternative payment methodologies; process for change in scope of services; rate setting for new clinics and new organization sites; base year cost report submission; allowable costs and consideration of the Minnesota health care provider tax.

DHS staff, MNACHC and FQHC providers are in agreement with all components detailed in this report with the exception of two areas for which there is considerable general agreement, but details must be finalized before full agreement can be reached. Those two areas are the base year inflator and what is considered an allowable cost.

II. Legislation

The commissioner of human services shall develop a recommendation for a new alternative payment methodology for federally qualified health centers and rural health clinics that covers the cost of all medical assistance services provided by federally qualified health centers or rural health clinics, and is in accordance with current Medicare cost principles as applicable to federally qualified health centers and rural health clinics. The recommendation for the new alternative payment methodology must:

(1) Be made in consultation with the state's federally qualified health centers and rural health clinics;

(2) Include regular rebasing of costs; and

(3) Take into consideration aspects of the current Medicare payment methodology to federally qualified health centers and rural health clinics.

The commissioner shall present the recommendation for a new alternative payment methodology to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 15, 2016.

III. Introduction

The 2015 Legislature requested a recommendation for a new alternative payment methodology (APM) for federally qualified health centers (FQHC) and rural health clinics (RHC) that covers the cost of all Medical Assistance (MA) services.

As background, a prospective payment system (PPS) was created for FQHCs and RHCs by the Benefits Improvement and Protection Act (BIPA) of 2000, section 702. BIPA required state Medicaid programs to pay the PPS rate, but also allowed States to offer APMs which must pay at least what the center or clinic would receive under PPS. Under current law, Minnesota has three different APMs:

- APM I is the cost based APM
- APM II is the PPS rate plus two percent health care provider tax; and
- APM III is the 200 percent payment of APM I or APM II when a qualifying medical and mental health visit occur on the same day

Using these rate methodologies, an encounter rate is established for each center or clinic site for a medical encounter. For center or clinic sites that provide dental services, a separate encounter rate has been established for dental encounters. A center or clinic can receive one medical encounter and/or one dental encounter per day per patient.

The basis of a prospective payment is to make a single payment per day to a clinic on any day where there is a face to face encounter involving services with certain qualifying health care providers. A prospective payment in effect divides the allowable costs of a clinic by the expected number of qualifying encounters to establish the encounter rate. This prospective encounter rate structure provides clinics with a level of stability and predictability with respect to their payments. The prospective encounter rate payment applies to services delivered to MA enrollees in both fee-for-service and managed care delivery systems. DHS is required each year to ensure the APM payments to each provider are equal to or greater than the payments the provider would have received under the PPS methodology. The current APMs, because they generally build off of the original PPS rate, are based on very old costs and apply historical restrictions established by Medicare that can reduce the per encounter payment rate. The historical costs and calculated rates are trended forward annually for inflation. Not surprisingly, however, costs and cost centers within FQHCs and other health provider settings have changed dramatically over the past 15 years. As a result, the accuracy and reliability of the current payment rates have been questioned.

The current FQHC payment system presents significant operational challenges for providers and DHS. The encounter payments, particularly those for services delivered to managed care enrollees, have been administratively challenging for both DHS and the clinics. While some centers and clinics have completed changes in scope which allow them to incorporate new costs and patient encounters, the current change in scope process can take a long time

and require administrative resources from DHS and the clinics. In addition, it is difficult for a center or clinic to predict in advance whether any rate changes resulting from a change in scope will be substantial enough to create a change in their encounter rate since other concurrent changes in practice may have created efficiencies and reduced costs in some areas over time.

In consultation with the MNACHC and FQHC providers, the DHS submits this report which details the recommendation of a new APM rate structure to replace the existing APMs. The proposed new APM recommendation addresses 12 major components:

1. Rate Structure
2. Rebasing frequency
3. Base years for obtaining costs
4. Effective date
5. Inflation factors
6. Quality measures
7. Existing APMs
8. Changes in scope of services between rebasing periods
9. Rates for new clinics and new sites
10. Cost report submission and timelines
11. Allowable costs
12. Healthcare provider tax

IV. Alternative Payment Methodology

The APM outlined in this next section will bring greater transparency to the actual costs and payments made for FQHC and RHC clinics, will modernize and clarify the processes for establishing and updating rates, and will promote greater efficiency and accountability for both DHS and providers.

The recommended APM, as described in Table 1, was developed in consultation with the MNACHC and FQHC providers. There is full agreement on 10 of the 12 components of the proposed APM. Table 1 was submitted by MNACHC. The table outlines each component of the APM, provides a summary of the DHS proposal as well as MNACHC's recommendations with input from FQHC providers. The "DHS Proposal" column reflects input from MNACHC and FQHC clinics and is a summary of how the corresponding component will be addressed under the new APM.

.

Table 1: Recommended future state APM

APM Component	DHS Proposal	MNACHC Recommendation
1. Rate Structure	Organization Rate	MNACHC supports this position.
2. Rebasing	Every Two Years (CY2020, CY2022, etc.)	MNACHC supports this position.
3. Base Years	Medicare cost reports from 2014 ("final settled") and 2015 (potentially "final settled") due six months after 2015 fiscal year end.	MNACHC supports this position.
4. Effective Date	2018 (with 2014/2015 as base year)	MNACHC supports this position.
5. Inflator	a) DHS will evaluate using the Personal Consumption Expenditures (PCE) inflator as a "bridge" between the 2014 and 2015 base year and the effective date of 2018.	MNACHC recommends using the PCE as the inflator for the three-year period between 2014/2015 and 2018.

APM Component	**DHS Proposal**	**MNACHC Recommendation**
	b) DHS will evaluate using the Medicare Economic Index (MEI) in the year between "re-basings."	MNACHC recommends using the MEI as the inflator between "re-basing" years. In addition, MNACHC recommends incorporating a wage increase inflator as well.
6. Quality Measures	DHS would establish a workgroup with FQHCs to establish future measures to evaluate the outcome of APM.	MNACHC recommends establishing a workgroup and is amenable to a collaborative discussion to evaluate APM relative to non-clinical measures – e.g. access to care.
7. APMI, II and III	a) APM I, II and III would be discontinued. PPS and APMIV would be the options for FQHCs.	MNACHC recommends eliminating APM I and III. MNACHC will evaluate the impact of removing APM II. An APMIV without "caps and screens" or no use of the Medicare FQHC PPS "aggregate mean" will be evaluated against projected APMII rates.
	b) MNCare ("provider tax") will be an add-on to PPS and APMIV.	MNACHC supports this position.

APM Component	DHS Proposal	MNACHC Recommendation
7. APM I, II and III (Cont'd)	c) For APMIV, DHS does not apply the "productivity caps and screens" the Medicare PPS FQHC "aggregate mean" upper payment limit.	MNACHC supports this position.
	d) Two encounters per day (medical and mental) health are allowed contingent upon CMS' re-definition of an encounter. Without CMS' approval, rate calculation will factor same day visits by excluding same-day visits from the visit count.	MNACHC supports this position.
8. Change in Scope of Services	a) Applicable to increase or decreases to any one rate (medical versus dental) greater than 2 ½ percent.	MNACHC supports this position.
	b) FQHCs should submit change of scope to DHS within seven (7) days of submitting scope change to the federal Health Resources Services Administration (HRSA). The DHS effective date of the change is the date HRSA approves the change. If the change is not implemented, the prior rate for the FQHC is restored.	MNACHC supports this position.
	c) For non-HRSA scope changes, DHS requests that FQHCs prospectively inform DHS of their potential service changes. The effective date of the rate change is the date DHS receives the formal change of scope request	MNACHC supports this position.
	d) DHS will provide a "look-back" period to evaluate a full year of FQHC costs relative to the scope change against the accuracy of the rate.	MNACHC supports this position.
8. Change in Scope of Services (Cont'd)	e) DHS will provide the FQHC an initial response related to the FQHC's change of scope within 30-45 days of submission. Final approval will be	MNACHC supports this position.

APM Component	**DHS Proposal**	**MNACHC Recommendation**
	within 90-120 days of submission. In addition, this timeline can be waived to seek additional information if both DHS and an FQHC mutually agree that this is necessary.	
9. Rate Setting for New Clinic and New Site	a) **New Organization/Not-operational** – DHS will establish APM rate using a caseload comparison of other FQHCs within 30 miles (RHCs within 60)until the clinic has a minimum of one (1) year to complete base cost year report.	MNACHC supports this position.
	b) New Organization/Operational – DHS will establish APM rate using the following hierarchy of resources: 1] base year Medicare cost reports; 2] caseload comparison of FQHCs within 30 miles(RHC- 60 miles); or 3] audited financial reports.	MNACHC supports this position.
	c) **Existing FQHC/New Site** – Provide Organization's rate	MNACHC supports this position.
10. Base Year Cost Report Submission	a) DHS will create a checklist of required information including: finalized Medicare cost report for	MNACHC supports this position.

APM Component	DHS Proposal	MNACHC Recommendation
	year one, preliminary Medicare cost report for year two, mapping, spreadsheet of face-to-face visits, etc. Base year costs reports are due six months from cost report year end.	
	b) DHS will respond to providers within 90 days whether information is complete or additional information is needed.	MNACHC supports this position.
	c) For rates to begin January 1, 2018, FQHCs shall submit "checklist items" by September 30, 2017.	MNACHC supports this position.
	d) Failure to meet September 30, 2017 deadline will result in FQHC receiving their PPS rate on January 1, 2018.	MNACHC supports this position.
	e) Delayed APM IV rates, will be started at the beginning of each quarter, two quarters after the date DHS received required "checklist" items from the FQHC.	MNACHC supports this position.
	f) APM IV rates will not be retroactively assigned.	MNACHC supports this position.
	g) A new appeal process is established and provides a 60-day window for appeal. Rates will be transmitted to the FQHC through the MN-ITS mailbox and an "alert" notice will be sent to FQHC CEOs and CFOs.	MNACHC supports this position.
11. Allowable Costs	DHS will include direct patient care costs along with patient-related support services	MNACHC is in general agreement with this

APM Component	DHS Proposal	MNACHC Recommendation
	as an "allowable cost" for Medical Assistance (MA) reimbursement.	approach. MNACHC is recommending costs related to electronic health records, patient management system, community health workers and care coordination activities are included in the definitions of direct patient costs and patient-related costs.
12. MinnesotaCare Tax	DHS will provide the 2% as an "add-on" to both the PPS and APMIV	MNACHC supports this position.

Two of the twelve components have considerable general agreement between DHS and MNACHC, but certain details must be finalized before full agreement can be reached. The two components requiring further discussion are inflation factors and allowable costs.

Inflation factors are used for two purposes in the new APM – to trend the rates forward in the year between one rebasing and the next and to trend costs forward from the base years to the current rate year during the initial and subsequent rebasing years. There is full agreement to use the change in the Medicare Economic Index (MEI) for trending the rates forward in the year between rebasing. The MEI is the annual inflation factor required to be used for the current PPS, so maintaining alignment with PPS makes sense both operationally and policy wise. DHS has also proposed using the MEI for the trending forward the base year costs, since doing so would allow greater ability to compare to PPS rates, which DHS is required to do each year. Centers and clinics have expressed concern that the MEI does not sufficiently reflect some of the main cost drivers such as staff salaries. MNACHC recommends using the Health Care Personal Consumption Expenditure (PCE) as the base year inflator.

The MEI, which is a measure of physician practice cost inflation, represents an increase of 1.1% for 2016. The MEI is adjusted annually by the Centers for Medicare and Medicaid Services (CMS). The average Health Care PCE index for the US and Minnesota from 1999 to 2014 were 5.6% and 5.14% respectively. While neither measure may be perfectly aligned to represent the actual changes in costs for FQHCs and RHCs in Minnesota, it has been

agreed that DHS could establish and use an average trend of FQHC and RHC allowable costs once DHS has at least three years of cost reports. This would more accurately reflect the true changes in costs over time for Minnesota providers, and would replace the use of a national index for trending forward costs from the base years to the current year. DHS is open to discussion regarding alternatives to the MEI to be coupled with efficiency, cost controls and to be cognizant of DHS administrative costs.

The second area where there is general agreement, but further discussion and finalization is needed is in the definition of allowable costs. DHS currently aligns with Medicare cost principles and applies reasonableness standards when considering whether a cost should be included in the rate. In conjunction with the development and implementation of a new APM, DHS, in consultation with the FQHCs and RHCs will be required to clarify what constitutes an allowable cost as well as what would be considered an unallowable cost.

V. Report recommendations

The DHS recommendation is to implement an APM IV for FQHC and RHC on January 1, 2018 featuring:

- A rate structure based on an organization rather than a specific clinic or region. All clinics within an organization will receive the same rate rather than differing rates per clinic or region of the state.
- Initial years costs based on 2014 and 2015 calendar or fiscal year
- Rebasing every two years
- An MEI base year and bi-annual inflator or consideration of alternatives to the base year MEI. Further discussion with MNACHC and providers is needed to resolve this issue
- A quality measure workgroup composed of participants from MNACHC, the FQHC and RHC provider communities and DHS
- Discontinuing APM I, II, III resulting in maintaining PPS and APM IV as the only payment methodology options (eventually this will constitute a single APM) starting January 1, 2018.
- Reimbursing two separate encounters per day (medical and mental health) contingent upon CMS accepting the definition of an encounter
- Apply a change in scope of services process for any increase or decrease to any one rate (medical or dental) greater than two and one half percent, effective the date the scope change is submitted or the date the change in scope of services occurs, whichever is later
- A new organization may select an APM IV rate once the organization has submitted to the DHS a minimum of one of the base year Medicare cost reports. Until that time, the organization will be assigned a PPS rate based on caseload comparison of an FQHC within 30 miles or an RHC within 60 miles
- An existing FQHC and/or RHC organization's new site will be assigned the organization's existing APM rate
- Established timelines for implementation of new rates that require rates be implemented on a quarterly basis, based on receipt of cost report submissions two quarters previous to the rate implementation. For example, if cost reports are submitted only four months from the new rate year, the effective date of the new rate for that organization will be delayed until the second quarter of the new rate year

- DHS established timelines for base year report submissions, supporting documentation, response times for both DHS and providers, rate implementation and a provider appeal process.

- DHS will include direct patient care costs along with patient related support services as allowable costs for MA reimbursement. DHS will work with internal partners as well as MNACHC to determine and clarify what costs will be considered allowable direct patient care costs

- DHS will assign the two percent health care provider tax as an add-on to the PPS or APM IV rate, rather than build the cost into the rate. Reimbursing for the tax as an add-on allows sufficient flexibility if the tax should change in the future.

VI. Conclusion

DHS, MNACHC and FQHC providers believe that the current prospective payment system methodology does not adequately reflect the current health care cost trends and results in payment rates that may not accurately reflect a clinic's costs.

DHS staff, MNACHC and FQHC providers have worked together to develop the APM outlined in this report and are in agreement with all components detailed in this report with the exception of two areas for which there is considerable general agreement, but details must be finalized before full agreement can be reached. Those two areas are the base year inflator and what is considered an allowable cost. We remain confident we can continue to work together to finalize those remaining details.

The recommended APM outlined in this report will bring greater transparency to the actual costs and payments made for FQHC and RHC clinics, will modernize and clarify the processes for establishing and updating rates, and will promote greater efficiency and accountability for both DHS and providers. DHS is willing to provide technical assistance to legislators and stakeholders on legislation that reflects the proposed new APM.

VII. Appendix

MNACHC APM
February 5 2015.pdf

Members who participated in discussions regarding FQHC and RHC APM:

Marie Zimmerman – DHS
Julie Marquardt – DHS
Sara Drake – DHS
Diogo Reis – DHS
Patrick Hultman - DHS
Liz Backe – DHS
Jo Ann Sharkshnas – DHS
Jonathan Watson – MNACHC
Jinny Johnson – MNACHC
Phil Griffin – MNACHC
Colleen McDonald – Community University Health Care Center
Kris McKeon – Community University Health Care Center
Steve Knutson – Neighborhood Health Source
Mike Holmes – Cook Area Health Services
James Platten – Open Cities
Jaeson Fournier – West Side Community Health Services
Bill Tendle – Southside Community Health Services