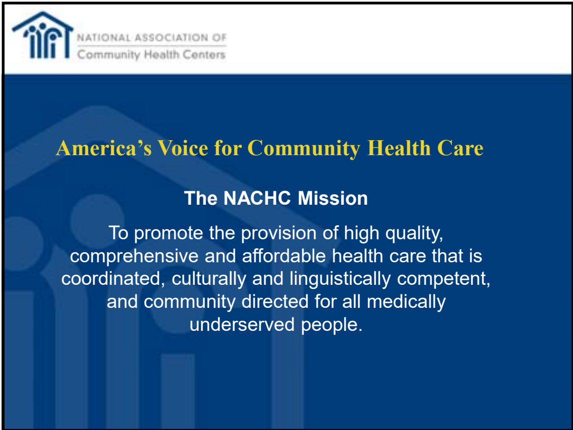
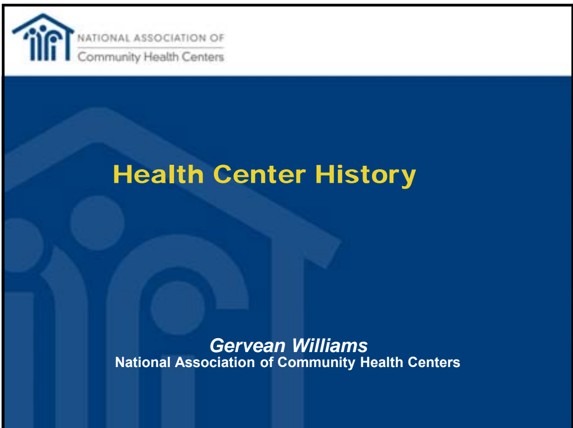
NATIONAL ASSOCIATION OF
Community Health Centers
America's Voice for Community Health Care


NATIONAL ASSOCIATION OF
Community Health Centers
America's Voice for Community Health Care
The NACHC 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 people.


NATIONAL ASSOCIATION OF
Community Health Centers
Health Center History
Gervean Williams
National Association of Community Health Centers

The Health Center Movement

The War on Poverty-Lyndon B Johnson

The first health centers

Neighborhood Health Centers

Boston and Mound Bayou

The Timeline

1965
100,000

1975
1 million

1985
5 million

2000
10
Million

2009
20
Million

2015
24
Million

330 Grantee

- Health Center Program Statute:
- Section 330 of the Public Health Service Act (42 U.S.C. §254b)
- Program Regulations (42 CFR Part 51c and 42 CFR Parts 56.201-56.604 for Community and Migrant Health Centers)
- Grants Regulations (45 CFR Part 74)

Health Center Program Requirements

- Needs Assessment: Health center demonstrates and documents the needs of its target population, updating its service area, when appropriate. (Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act)
- Required and Additional Services: Health center provides all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals. (Section 330(a) of the PHS Act) Note: Health centers requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services (Section 330(h)(2) of the PHS Act

Requirements Cont.

- Staffing Requirement: Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed and privileged. (Section 330(a)(1), (b)(1)-(2), (k)(3)(C), and (k)(3)(I) of the PHS Act)
- Accessible Hours of Operation/Locations: Health center provides services at times and locations that assure accessibility and meet the needs of the population to be served. (Section 330(k)(3)(A) of the PHS Act)
- After Hours Coverage: Health center provides professional coverage for medical emergencies during hours when the center is closed. (Section 330(k)(3)(A) of the PHS Act and 42 CFR Part 51c.102(h)(4))

Requirements Cont.

- Hospital Admitting Privileges and Continuum of Care: Health center physicians have admitting privileges at one or more referral hospitals, or other such arrangement to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking. (Section 330(k)(3)(L) of the PHS Act)
- Sliding Fee Discounts: Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay
- Quality Improvement/Assurance Plan: Health center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records.

Requirements Cont.

- Key Management Staff: Health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. Prior approval by HRSA of a change in the Project Director/Executive Director/CEO position is required. (Section 330(k)(3)(I) of the PHS Act, 42 CFR Part 51c.303(p) and 45 CFR Part 74.25(c)(2),(3))
- Contractual/Affiliation Agreements: Health center exercises appropriate oversight and authority over all contracted services, including assuring that any subrecipient(s) meets Health Center program requirements. (Section 330(k)(3)(I)(ii), 42 CFR Part 51c.303(n), (t)), Section 1861(aa)(4) and Section 1905(l)(2)(B) of the Social Security Act, and 45 CFR Part 74.1(a) (2))
- Collaborative Relationships: Health center makes effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. The health center secures letter(s) of support from existing health centers (section 330 grantees and FQHC Look-Alikes) in the service area or provides an explanation for why such letter(s) of support cannot be obtained. (Section 330(k)(3)(B) of the PHS Act and 42 CFR Part 51c.303(n))

Requirements Cont

- Financial Management and Control Policies: Health center maintains accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separates functions appropriate to organizational size to safeguard assets and maintain financial stability.
- Billing and Collections: Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures. (Section 330(k)(3)(F) and (G) of the PHS Act)
- Budget: Health center has developed a budget that reflects the costs of operations, expenses, and revenues (including the Federal grant) necessary to accomplish the service delivery plan, including the number of patients to be served. (Section 330(k)(3)(D), Section 330(k)(3)(I)(i), and 45 CFR Part 74.25)
- Program Data Reporting Systems: Health center has systems which accurately collect and organize data for program reporting and which support management decision making. (Section 330(k)(3)(I)(ii) of the PHS Act)
- Scope of Project: Health center maintains its funded scope of project (sites, services, service area, target population and providers), including any increases based on recent grant awards. (45 CFR Part 74.25)

Last Requirements

- Board Authority: Health center governing board maintains appropriate authority to oversee the operations of the center
- Board Composition: The health center governing board is composed of individuals, a majority of whom are being served by the center and, this majority as a group, represent the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex.
- Conflict of Interest Policy: Health center bylaws or written corporate board approved policy include provisions that prohibit conflict of interest by board members, employees, consultants and those who furnish goods or services to the health center

Medicaid PPS

Documents Relevant to PPS Implementation

Federal Documents

- Federal Medicaid Statute
- Medicare FQHC Regulations
- State Medicaid Manual
- CMS State Medicaid Directors letters and other Federal Policy Publications

State Documents

- State Medicaid Plan and Plan Amendments
- State Statutes
- State Regulations
- State Manuals and other State Policy Publications
- Case Law
- NACHC's Annual State-by-State PPS Update and other NACHC Publications

OBRA 89/90: Establishment of FQHC

- *Omnibus Budget Reconciliation Acts of 1989 and 1990*
- Establish FQHC and FQHC Services for Medicare/Medicaid
  - Medicare FQHC regulations: 42 CFR 405.2400 et seq.
  - Medicare RHC/FQHC Manual (Pub. 27)
  - Reasonable cost payments intended to protect grant dollars from low Medicare/Medicaid reimbursements

Cost-Based Reimbursement (Reusable Cost)

- Medicare statute and regulations (42 CFR 413)
- Allowable costs for Medicaid-covered services
- Allowable costs for Medicaid services

  divided by

  number of face to face encounters equals

  per visit rate

- Example:

  $1,000,000 allowable costs

  $ 10,000.00 visits

  All inclusive per visit rate=$100

Medicaid-covered Services Establishment of FQHC

- FQHC Services, as defined in Medicaid Statute: 42 USC §§ 1396a(a)(10)(A) and 1396d(a)(2)(C) and 1396d(l)(2)
  - FQHC services (Medicare rural health clinic services) and any other ambulatory service in the State Medicaid plan provided by the FQHC

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA)

[P.L.106-554]

- Replaces reasonable cost with Prospective Payment System (PPS)

The PPS Baseline

- For services provided between January 1 – September 30, 2001
- Payment calculated on a per visit basis
- States require to pay current FQHCs 100 percent of the average of their reasonable costs of providing Medicaid-covered services during FY1999 and FY2000
- Adjusted to take into account any increase (or decrease) in the scope of services furnished during FY2001 by the FQHC
- Issues: Caps, Screens, Services covered, etc.

Calculating Future Rates: Federal Requirements

- For FY2002 and each fiscal year thereafter, each FQHC is entitled to a payment amount equal to the amount the center was entitled to in the previous fiscal year, adjusted by:
  - The change in the Medicare Economic Index (MEI) for primary care services, and
  - Increase (or decrease) in the scope of services furnished by the FQHC during that fiscal year.

Change in Scope of Services: What may be considered a change…

- Adding or subtracting a billable service? A non-billable service – Yes, if it's a new service?
- New sites? New capital costs?
- Intensity of Medicaid services?
- Volume of Medicaid cost or visits - No

PPS for New FQHCs:

- For entities that qualify as FQHCs after fiscal year 2000, the State plan shall provide for payment 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 for the fiscal year for other centers or clinics located in the same or adjacent area with a similar case load or
  - In the absence of such a center, in accordance with Medicare FQHC regulations and methodology, or

  based on other tests of reasonableness as the Secretary may specify

PPS for New FQHCs:

- For each fiscal year following the first year in which the entity qualifies as a FQHC, the State plan shall provide for the payment amount to be calculated in accordance with the PPS.

Wrap-Around Payments Federal Requirements

- States required to make supplemental payments to FQHCs that subcontract (directly or indirectly) with Managed Care Entities
- Supplemental payment is the difference between the payment received by the FQHC for treating the MCE enrollee and the payment to which the FQHC is entitled under the PPS
- MCE still must pay FQHC an amount comparable to what it pays similar providers for similar services. 42 USC 1396b(m)(2)(A)(ix)

Wrap-Around Payments Federal Requirements

- Under PPS, State must make supplemental payments at least every 4 months.
- Issues: How will State determine amount of MCO payments to FQHC? What about MCO payment denials (for non-enrollees, ineligibles, services not part of MCO contract, etc)? What about bonus payments and shared savings? (see September 27, 2000 SMD letter).

Alternative Methodologies: Federal Standards

- State and health center option
- Each individual FQHC has the option to agree (or not to agree) to any alternative payment methodology
- Alternative payment methodology must reimburse a FQHC in an amount that is not less than the amount the FQHC is entitled to under PPS

Alternative Methodologies: Implications

- PPS rate will be "measuring stick" to determine whether rate under alternative methodologies are lawful in subsequent years – As PPS rate increases annually with inflation, so should the rate offered under the alternative methodology

Alternative Methodologies: Implications

- How is FQHC's agreement to an alternative methodology documented?
  - Is it in the FQHC's provider agreement?
  - Is there a separate MOA or MOU? Between the FQHC and the State? Between the PCA (on behalf of all FQHCs) and the State?

Common PPS Issues:

1. Number of visits per day
2. What is a billable visit?
3. What services are included as FQHC services? Other ambulatory services? What RHC services?
4. Offsite services?
5. What is a change in scope of service?
6. Procedure for change in scope?
7. How to calculate change in scope
8. Timely payments generally and in wrap-around
9. Alternative payment methodology vs. wrap-around
10. 1115 waivers and FQHCs

--And what about CHIP?

See CMS-SHO #10-003 (2/4/10)

For additional questions contact:

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