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General Considerations under Federal law and FQHC Payment Protections

Adam J. Falcone, Esq.

Partner

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Adam J. Falcone

- Partner in FTLF's national health law practice.
- Counsels health centers, behavioral health providers, and provider networks on a wide range of health law issues, including fraud and abuse, reimbursement and payment, and antitrust and competition matters.
- Began his legal career in Washington, D.C. as a trial attorney in the Antitrust Division's Health Care Task Force at the U.S. Department of Justice.
- Served as Policy Counsel for the Alliance of Community Health Plans, representing non-profit and provider-sponsored managed care organizations before Congress and the Executive Branch.
- Received a B.A from Brandeis University, an M.P.H. from Boston University School of Public Health, and a J.D., cum laude, from Boston University School of Law.

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AGENDA

To what extent, if any, does federal law limit health centers from participating in Value-Based Payment (VBP) arrangements?

- General Considerations under Federal Medicaid Law
- Legal Considerations under Section 330 of the PHSA
  - Use of Grant Funds
  - Use of Program Income
- FQHC Payment Protections in Medicare and Medicaid
  - Wrap-Around Payment Requirements
  - Application of Wrap-Around to VBP Arrangements
  - Alternative Payment Methodologies and VBP

FEDERAL MEDICAID LAW

No less than three different provisions in Title XVIII (the Medicaid Statute) allow a single FQHC to participate in downside risk arrangements under Medicaid managed care, either by declaring an FQHC eligible to serve as a Medicaid MCO or permitting a state to pay an FQHC under a full-risk capitated contract.

1)42 U.S.C. § 1396b(m)(1)(A) and (C)(ii)(IV). Qualifies an FQHC as a "Medicaid managed care organization" eligible to receive a full-risk contract for Medicaid services without meeting generally applicable state solvency requirements that the Medicaid Act imposes on such MCOs.

2)42 U.S.C. § 1396b(m)(2)(B)(i). Any Section 330 Public Health Service Act grantee that received a grant of at least $100,000 during "the fiscal year ending June 30, 1976" and has, since then, been a continuous recipient of Section 330 grants of at least $100,000, is eligible to receive a full-risk capitated contract.

3)42 U.S.C. § 1396b(m)(2)(G). Applies to current Section 330 grantees with at least two continuous years of such grants for at least $100,000 immediately prior to its current year's Section 330 grant (of at least $100,000), is eligible to receive a full-risk capitated contract from a state without requiring the FQHC to be qualified as a Medicaid MCO.

OTHER LEGAL CONSIDERATIONS

- State insurance law may prohibit providers, including health centers, from accepting risk of loss. States can require:
  - Licensure
  - Reserves
  - Stop-Loss insurance
- Medicaid Policies may also limit eligibility for participation in Medicaid VBP arrangements to certain types of providers, or group of providers.
  - Example: New York State does not permit FQHCs to be "lead VBP Contractors" in downside shared risk arrangements and global capitation.

SECTION 330 GRANT REQUIREMENTS

Health centers participating in risk-based contracts must observe the following requirements relating to the use of grant funds and program income:

1)Permitted Use of Grant Funds. Pursuant to Section 330's implementing regulations, grant funds "may be expended solely for carrying out the approved project in accordance with section 330 of the Act, the applicable regulations of this part, the terms and conditions of the award, and the applicable cost principles prescribed in 45 CFR part 75, subpart E." *42 C.F.R. § 51c.107(a).*

2)Capitation Payments. Even when a health center renders services on a "prepaid capitation basis," the grant funds may only be used for the cost of delivering health services related to "project services," *i.e.*, services within the health center's scope of project. *42 CFR § 51c.107(b)(5).*

3)Reserve Funds. Section 330 implementing regulations permit an FQHC to use its grant funds for the cost of developing and maintaining a reserve fund where required by State law for prepaid health care plans. *42 CFR § 51c.108(b)(8).*

SECTION 330 GRANT REQUIREMENTS

(continued)

4)Downside Financial Risk. In general, FQHCs cannot accept down-side financial risk that may result in paying for services outside its scope of project with Section 330 grant funds.

- "[I]f a health center is at financial risk for the costs of services beyond those covered under its scope, it must ensure that no Section 330 funds are used to offset the costs of these services. Since most health centers' approved scopes of project are limited to primary and preventive care, this means that Section 330 funds may not be used to offset the costs of specialty, hospitalization, and other types of care."

  BPHC, Letter to Health Center Director, February 22, 2011.

5)Program Income. Federal law also restricts use of program income (*e.g.*, revenue generated from a grant-funded activity) to the health center's operational costs and to furthering the objectives of the health center's scope of project, where not otherwise prohibited by statute. *42 U.S.C. § 254b(e)(5)(C).*

  – Note: In certain circumstances, the assumption of a reasonable amount of down-side financial risk might further the purposes of an approved scope of project if the arrangement is designed to reduce avoidable hospital and specialty care for the health center's patients.

FQHC PPS Protections in Medicaid and Medicare

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MEDICAID SUPPLEMENTAL ("WRAP-AROUND") PAYMENTS

Managed Care. PPS protections apply in managed care settings regardless of whether an FQHC contracts directly with Managed Care Organizations (MCOs) or indirectly through Accountable Care Organizations (ACOs), Independent Practice Associations (IPAs), or Health Center-Controlled Networks (HCCNs).

- **Wraparound Payments.** Federal statute requires Medicaid agencies to make supplemental payments to FQHCs to ensure total payments for Medicaid managed care enrollees are equal to the amount that would have been paid under the PPS methodology. *Social Security Act § 1902(bb)(5)(A).*
- **Minimum Frequency.** Payments must be made according to an agreed-upon schedule, but "in no case less frequently than every 4 months". *SSA § 1902(bb)(5)(B).*
- **Reconciliation.** Per CMS guidance, states must conduct a "reconciliation" annually, or more frequently at the State's option, to ensure that total payments to FQHCs for Medicaid managed care enrollees are equal to the PPS (or APM) amount.

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MEDICAID WRAPAROUND PAYMENTS

Incentive Arrangements. CMS has long-standing policy that incentive amounts (both positive and negative) are separate from the MCO's payment for services and should not be included in Medicaid's calculation of supplemental payments.

According to CMS:

- Financial incentives provide the provider with an incentive to reduce unnecessary utilization of services or otherwise reduce patient costs.
- Incentive amounts should *not* be included in the State's calculation of supplemental (wraparound) payments
- Inclusion of incentives in calculating wrap payments would negate financial impact incentives are designed to provide
- State's wraparound payment obligation should be determined using the baseline payment under the contract for services being provided, without regard to the effects of financial incentives

State Medicaid Directors Letter, "Policy Regarding FQHCs/RHCs " (September 27, 2000).

https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd092700.pdf

MEDICAID WRAPAROUND PAYMENTS

Incentive Payments. More recently, CMS affirmed that positive financial incentives paid by MCOs allow FQHCs to earn revenue over and above the amounts required under the PPS reimbursement methodology.

> "[. . .] FQHCs and RHCs are required by statute to be reimbursed according to methodologies approved under the State plan. In the event a particular financial incentive arrangement related to meeting specified performance metrics for these providers is part of the provider agreement with the managed care plan, **those financial incentives must be in addition to the required reimbursement levels specified in the State plan**."

CMS, Medicaid Managed Care Final Rule, Federal Register (Vol. 81), Friday, May 6, 2016, p. 27577.

PAY FOR PERFORMANCE (P4P) INCENTIVES

PAYMENT METHOD	RATE	UNITS OF SERVICE	REVENUE
Base Payment from MCOs for FQHC Services	Medicaid Fee Schedule	CPT/HCPCS	$75,000
P4P Incentive Payments	$50 / patient outcome	500 patients	[+$25,000?]
PPS Methodology	$150 / visit	1,000 encounters	$150,000

State Wraparound Payment = [PPS Methodology] – [Base Payments]

State Wraparound Payment = $150K - $75K = $75K

Total Payment Received for FQHC Services = $75K + $75K= **$150K**

Combined Payments for FQHC Services and Incentive Payments:

If incentive earned, then $150K +$25K = **$175K**

If incentive lost, then: $150K + 0 = **$150K**

MEDICAID WRAPAROUND PAYMENTS

Participation in Value-Based Arrangements. When it published the Medicaid Managed Care Final Rule, CMS stated:

- "The determination to apply value-based purchasing models, delivery system reform initiatives, or performance improvement initiatives to a particular provider type must take into account statutorily mandated payment levels or methodologies, as well as additional considerations such as conditions for grant funding from other federal agencies. . . . "

  Federal Register (Vol. 81), Friday, May 6, 2016, p. 27586

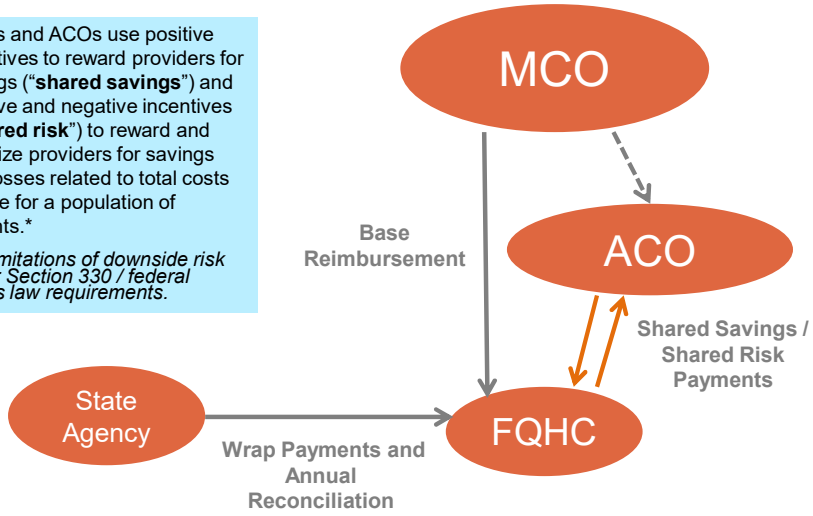
As applied to Federally Qualified Health Centers (FQHCs) this means:

- An FQHC's participation in value-based purchasing models must comply with statutorily mandated payment levels (*e.g.*, Medicaid and Medicare PPS) and federal grant requirements under Section 330 of the Public Health Service Act.

SHARED SAVINGS / SHARED RISK PROGRAMS

- MCOs and ACOs use positive incentives to reward providers for savings ("**shared savings**") and positive and negative incentives ("**shared risk**") to reward and penalize providers for savings and losses related to total costs of care for a population of patients.*

**Note limitations of downside risk under Section 330 / federal grants law requirements.*



SHARED SAVINGS / SHARED RISK PROGRAMS

PAYMENT METHOD	RATE	UNITS OF SERVICE	REVENUE
Base Payment for FQHC Services from MCO	Medicaid Fee Schedule	CPT/HCPCS	$1,125,000
PPS Wrap Payments from State Medicaid Agency	$150 / visit	15,000 encounters	$1,125,000
Upside Gain from MCO	75% of Shared Savings	n/a	[+$750,000?]
Downside Loss from FQHC	25% of Shared Losses	n/a	[-$250,000?]

State Wraparound Payment = [PPS Methodology] – [Base Payments]

State Wraparound Payment = $2.250M - $1.125M = **$1.125M**

Total Payment Received for FQHC Services: $1.125M + $1.125M = **$2.250M**

Total Payments for FQHC Services and Incentive Payments:

If shared gains, then $2.250M +$750K = **$3.0M**

If shared losses, then: $2.250M + (-$250K) = **$2.0M**

PRIMARY CARE CAPITATION

PAYMENT METHOD	RATE	UNITS OF SERVICE	REVENUE
Primary Care Capitation	$15 PMPM	9,000 member-months (~750 patients)	$135,000
Incentive Payment	$3 PMPM	9,000 member-months	[+$27,000?]
PPS Methodology	$150 / visit	2,500 encounters	$375,000

State Wraparound Payment = [PPS Methodology] – [Base Payments]

State Wraparound Payment = $375K - $135K = $240K

Total Payment Received for FQHC Services: $135K + $240K = **$375K**

Combined Payments for FQHC Services and Incentive Payments:

If incentive payment earned, then $375K +$27K = **$402K**

If incentive payment denied, then: $375K + 0 = **$375K**

PROFESSIONAL CAPITATION

PAYMENT METHOD	RATE	UNITS OF SERVICE	REVENUE
Professional Capitation	$50 PMPM	10,000 member-months	$500,000
• Base Payment for FQHC Services from MCO (per allocation)*	$18 PMPM	10,000 member-months	$180,000
• Non-FQHC Professional Services	$32 PMPM	10,000 member-months	$320,000
PPS Wrap Payments	$150 / visit	3,000 encounters	$450,000

State Wraparound Payment = [PPS Methodology] – [Base Payments]

State Wraparound Payment = $450K - $180K = **$270K**

Total Payment Received for FQHC Services: $180K + $270K = **$450K**

Total Payments for all Professional Services:

[FQHC Services] + [Non-FQHC Professional Services] = $450K +$320K = **$770K**

If cost of all Professional Services > $770K, then FQHC incurs a loss.

*Note: If not set forth in the MCO contract, State Medicaid agency should establish rules on how to properly allocate portion of professional capitation that applies to FQHC services.

RECOMMENDATIONS

- **Capitation.** FQHC enters 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. A state might count 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.
  - **Practice Pointer.** The contract between the FQHC and MCO should distinguish between compensation for the FQHC's own services and compensation for services furnished by other providers.
- **Payment Incentives.** 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 payment obligations.
  - **Practice Pointer.** The contract between the FQHC and MCO should separate out any bonuses or incentive payments, including those bonuses and payments made on a capitated basis.

ALTERNATIVE PAYMENT METHODOLOGY (APM)

- **Flexible Payment Models.** If a State Medicaid program wishes to pay FQHCs on a basis other than PPS, a state may implement an Alternative Payment Methodology ("APM").
- **Legal Protections.** States may implement an APM if three conditions are met:
  1) the APM is described in an approved state plan;
  2) the APM pays at least as equal to the PPS; and
  3) each FQHC under the APM consents to the arrangement.
- **State Responsibility.** States remain responsible for ensuring that FQHCs receive no less than what they would have received under the PPS methodology.
- **Reconciliation and Oversight.** Under managed care, states must continue their reconciliation and oversight processes to ensure that the managed care payments comply with the statutory requirements of the APM.

CMS, "FQHC and RHC Supplemental Payment Requirements and FQHC, RHC, and FBC Network Sufficiency under Medicaid and CHIP Managed Care", SHO # 16-006, April 26, 2016. https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16006.pdf

APM "CHECK-UP" QUESTIONS

- ❑ Does the state verify annually that FQHCs are paid at least PPS by keeping baseline PPS rates adjusted for inflation and changes in services?
- ❑ Does the state apply the Medicaid state plan's description/definition of an APM?
- ❑ Did the state obtain each FQHC's consent to an APM?
- ❑ Does the state conduct reconciliation and oversight activities to ensure that APMs directing managed care payments comply with APM requirements?

EXAMPLE: CAPITATED PAYMENT METHODOLOGY

- **Payment Methodology.** State converts each FQHC's current PPS rate to an equivalent Per-Member-Per-Month ("PMPM") rate based on historical patient utilization and attribution.
- **Annual Reconciliation.** The State will conduct quarterly and annual reconciliations based on actual utilization data to comply with federal requirements that FQHCs paid under the proposed APM receive no less than they would have received under the FQHC's current PPS methodology. The State will continue to adjust underlying PPS rates for inflation and changes in the scope of the FQHC's services.
- **Implementation.** State receives CMS approval of State Plan Amendment (SPA) describing the APM and permits an FQHC to decline reimbursement under the APM and retain encounter-based payment. Any FQHC that agrees to the APM can change its mind and revert to the encounter-based payment.
- **Conclusion.** State satisfies federal requirements of an FQHC Alternative Payment Methodology.

MEDICARE WRAPAROUND PAYMENTS

Managed Care. Similar to Medicaid, Medicare PPS reflects a bundled payment design that delivers high value primary care in both managed care and non-managed care settings.

•**Wraparound Payments.** Medicare must pay a wrap-around payment for the difference, if any, between an FQHC's payments from a Medicare MCO and what the FQHC would have received under its PPS rate. *42 C.F.R. 405.2469(b).*

•**IPA Contracts.** FQHCs are entitled to supplemental payments when they are "under contract (directly or indirectly) with [Medicare MCOs]." *42 C.F.R. 405.2469(a).*

•**Financial Incentives.** In calculating the amount of wrap-around, Medicare may not include financial incentives provided by health plans such as risk pool payments, bonuses, or withholds as health plan payments. *42 C.F.R. 405.2469(c).*

•**Quarterly Payments.** Medicare must make wrap-around payments to health centers on at least a quarterly basis. *42 U.S.C. § 1395w-23(a)(4)(A).*

KEY TAKE-AWAYS

- **Health centers may participate in downside risk arrangements with MCOs.** Nothing in federal law bars health centers from participating in downside risk arrangements with MCOs, subject to Section 330 regulatory requirements pertaining to the use of federal grant funds and program income.
  - Health centers cannot use Section 330 grant dollars to pay for out of scope services.
  - A health center that incurs a loss or liability under a downside risk arrangement may be able to use program income to pay for out of scope services if doing so furthers the purposes of the health center's approved scope of project.
- **A health center's participation in a downside risk arrangement with an MCO should have no positive or negative effect on a state's calculation of wrap-around payments.** CMS policy requires states to calculate wrap-around payments using the base payment for services provided by the FQHC, disregarding gains or losses under any downside risk arrangement.

Adam J. Falcone, Esq.
AFalcone@ftlf.com

Feldesman Tucker Leifer Fidell LLP
1129 20th Street NW, Suite 400
Washington, DC 20036
(202) 466-8960
www.ftlf.com