Defining an Effective Medicaid Change-in-Scope Rate Adjustment Process for FQHCs

NATIONAL ASSOCIATION OF Community Health Centers®

Statutory and Regulatory Requirements Concerning Change In Scope Rate Adjustments

The Medicaid FQHC PPS is a fixed, per-visit rate based on the historical costs of providing Medicaid services in FYs 1999 and 2000 (as defined in federal statute). Two categories of services are included in the cost-related FQHC PPS rate. "Federally-qualified health center services" are defined as the services of physicians, physician assistants, nurse practitioners, clinical psychologists, and clinical social workers, and may include the services of visiting nurses in the case of centers in areas with a shortage of home health agencies. (These are sometimes referred to as FQHC "core" services.) The FQHC benefit also includes any other ambulatory services that are offered by a specific FQHC and are included in the Medicaid state plan.[1]

Federal law, at Section 1902(bb)(3) of the SSA, requires states to provide in their Medicaid state plans for adjustments to the per-visit 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." The Medicaid statute does not define the term "increase or decrease in the scope of services." The law also does not prescribe a specific process states must use to adjust rates based on such changes. Guidance issued by the Centers for Medicare & Medicaid Services (CMS) in 2001 ("the 2001 PPS Guidance") stated that a change in the scope of services "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."[2] The 2001 PPS Guidance defined a change in the scope of services as "a change in the type, intensity, duration and/or amount of services."

States have considerable latitude in how they implement the Medicaid statute's change in scope requirement, but states may not implement the law arbitrarily or in a way that is contrary to the law's terms. CMS stated in the 2001 PPS Guidance that a "state must develop a process necessary for determining a change in scope of services."[3] An effective change in scope rate adjustment process has two basic features: 1) a definition of a qualifying event for a change in scope; and (2) a description of the methodology used to compute the change in rate. In addition, state policies should address various timing and procedure issues, such as the effective date of the rate change and available appeal process for FQHCs to dispute a state's rate adjustment decision.

Defining "Qualifying Events" for a Change In Scope

State Medicaid agencies should have a documented definition of a "change in the scope of services." Optimally, the definition should be formally included in the Medicaid state plan or in state regulations, so that affected FQHCs have notice of any change to the definition. The definition should at minimum include the four types of changes listed in the 2001 CMS issuance: changes in type, intensity, duration, and amount of services.

In many states, the above standards have not been met yet. The National Association of Community Health Center's (NACHC) 2018 assessment indicated that while about 36 PCAs reported that their state has a documented definition of a "change in the scope of services," at least nine of those states do not include in their definitions all four of the types of events listed in the 2001 PPS Guidance. Further, as noted above, PCAs from ten states indicated that their state did not have any change-in-scope definition.

As States develop policies, it is useful for them to distinguish a change in "type" of service from a change in "intensity, duration or amount" of a service. A change in type is different because it generally results from either an intentional decision by the health center to offer a new service or suspend an existing one, or from a policy decision or change in law by the state to cover a new type of service or suspend coverage of a service.

[1] SSA §§ 1905(a)(2)(C), 1905(l)(2)(A).

[2] Memorandum from Richard Chambers, Acting Director, Family and Children's Health Programs Group, Health Care Financing Administration (now CMS), to Associate Regional Administrators (Sept. 12, 2001), re: BIPA Section 702 PPS for FQHCs, at http://www.nachc.org/wp-content/uploads/2015/11/PPS-Q-As-2001.pdf.

[3] Ibd.

Because such a change is usually intentional, the inception of the change in scope (the date when a service was added or deleted) is easily specified, and the financial impact of the change is relatively straightforward to quantify. One key issue with a change in "type" is typically whether the service that has been added or removed was incorporated into the PPS rate of a given FQHC. The following sample definition of a "type" change illustrates this point:

> *The addition of a new FQHC service that is not incorporated in the baseline PPS or Alternative Payment Methodology (APM) encounter rate, or a deletion of an FQHC service that is incorporated in the baseline PPS or APM encounter rate.*

Notably, the addition or deletion of a service need not relate to discrete services performed by licensed clinicians in order to qualify as a change in "type." The 2001 PPS Guidance stated that "state agencies must add on the cost of new FQHC/RHC services even if these services do not require a face-to-face visit with a FQHC/RHC provider, e.g., laboratory, x-rays, drugs, outreach, case management, transportation, etc."[4]

Changes of "intensity, duration and amount" are less straightforward to define. Optimally, states should include in their policies a detailed, non-exclusive list of qualifying events that would qualify as each of the four categories of changes (i.e., the state plan amendment or regulations should indicate that the list of events "includes, but is not limited to….").

EXAMPLES OF THE FOUR TYPES OF QUALIFYING EVENTS FOR A CHANGE IN SCOPE

1 Change in Type:

- a health center chooses to offer a new discrete service that is covered under the state plan, and which has not been previously incorporated into its PPS rate
- a health center adds a new clinical program (e.g., one involving care coordination or disease management) that is not a standalone service, and which has not previously been incorporated into the PPS rate
- State amends the state plan to remove an ambulatory service that some FQHCs had offered (and had been incorporated into their rates)

2 Change in Intensity

- Health center adds new clinical equipment, resulting in more resource-intensive visits (e.g., cardiac stress tests added as feature of adult wellness visits)
- Health center's provider mix changes (e.g., through the addition of new employed or contracted specialist physicians)
- Health center adds new supporting clinical staff, resulting in more resource-intensive visits (e.g., behavioral health consultant included in well-child visits)
- Health center implements new technology relating to clinical care (e.g., new practice management or electronic health record system)

3 Change in Duration

- Health center's patient population mix changes (e.g., increase in adult patients due to Medicaid expansion), resulting more services/procedures performed per visit and greater average time per visit

4 Change in Amount

- Heath center develops new protocols that result in more services or procedures being performed in one visit and greater average time per visit (e.g., combined medical and behavioral health visits)

When defining qualifying events, some states apply a required minimum percentage change in costs as a threshold; for example, California's state plan provides that a change in costs will be considered a "scope-of-service change," for purposes of an FQHC's or RHC's rate adjustment application, only if (among other requirements) "[t]he net change in the FQHC's or RHC's per-visit rate equals or exceeds 1.75 percent for the affected FQHC or RHC site."[5] Depending on a particular situation, such a cost change percentage threshold can either help or harm a health center's financial interests. For example, a five percent threshold would be difficult to cross for a health center seeking a rate adjustment—especially when that threshold is applied to an all-inclusive rate which takes into account the cost of all covered services. In other words, the cost impact of any change in scope of services would have to be substantial before it would affect a center's overall PPS rate by five percent. On the other hand, such an annual "net change" threshold can foreclose a state from imposing a rate reduction due to a decrease in the scope of services.

[4] Memorandum from Richard Chambers, Acting Director, Family and Children's Health Programs Group, Health Care Financing Administration (now CMS), to Associate Regional Administrators (Sept. 12, 2001), re: BIPA Section 702 PPS for FQHCs, at http://www.nachc.org/wp-content/uploads/2015/11/PPS-Q-As-2001.pdf.

[5] California State plan, Att. 4.19-B, Page 6M. "Net change," in turn, is defined as "the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year."

Methodology for Computing the Change In Scope Rate Adjustment

Any methodology for calculating the rate adjustment generally involves the health center submitting a cost report documenting changes in costs in the year(s) in which a change-in-scope occurred. States commonly employ one of two different methods to calculate the cost associated with scope changes. The first method is to calculate the incremental cost of the new service or services, by taking into consideration only those categories of the cost report impacted by the scope change event. The second is to use the health center's overall cost per visit, as reflected on the cost report covering the year(s) when the scope change occurred.

While the second approach captures all changes and is easily administered, it can be advantageous or disadvantageous depending on how a center's costs have evolved since its PPS rate was calculated. Note that the premise of a change in scope rate adjustment is to capture in the rate the new costs associated with qualifying scope change events. A health center that has been particularly effective in managing its costs in the years since the PPS rates were set could be "penalized" due solely to gains in efficiency if its rate were to be adjusted using the total costs of the center in the relevant year (as opposed to the costs associated with only the change in scope of services).

In some instances where states have not had a working scope change rate adjustment policy in effect for many years, states have chosen to adjust the rate using the "overall cost per visit" approach in order to ensure that the new rate captures the cumulative effect of the changes in the scope of services experienced by the FQHC over numerous years.

Process and Timing Concerns

Process and timing have emerged as important policy issues in the states concerning the FQHC change in scope rate adjustment. A documented scope change rate adjustment policy does not benefit FQHCs if it is not consistently and timely enforced by the state.

At the most basic level, some states have never implemented a scope change rate adjustment policy at all—particularly those states that use an alternative payment methodology (APM). Under the Medicaid statute, a state may choose to use an APM in lieu of meeting the statutory PPS requirements, so long as (1) the APM results in payment at least equal to the PPS and (2) each affected FQHC agrees to the APM.[6] Some states have adopted an APM and subsequently have not consistently processed PPS rate adjustment applications for FQHCs that are paid under the APM. The 2001 PPS Guidance required that states annually compare each FQHC's PPS rate to any rate under an APM, to ensure that APM payment is at least equal to the PPS.[7] An accurate comparison is not possible if the state is not enforcing its documented scope change policies.

In addition, some states use timing restrictions for the rate adjustment that undermine the legal requirements regarding changes in scope. For example, a state might require health centers to provide advance notification of any change in the scope of services in order to qualify for a rate adjustment. As noted above, an "increase or decrease in the scope of services" may result from changes that are not associated with a concrete choice by the health center—for example, a change in the intensity of services resulting from a change in the patient mix toward individuals with more acute needs. Requiring advance notice of the change effectively precludes a rate adjustment for changes that do not result from a prospective choice by the FQHC or policy change by the state.

Another common timing restriction is for a state to require that change in scope rate adjustments take effect only prospectively (after the state completes the process of evaluating the application and developing a new rate). This is inconsistent with federal law, which provides that payment under the PPS for any given year shall be equal to the amount calculated for the preceding year and adjusted both for the MEI and "to take account any increase or decrease in the scope of services furnished by the center or clinic *during that fiscal year.*"[8] It is not uncommon for states to take a year or more to process. It is likewise important that state policies relating to the rate adjustments include procedural protections to ensure that applications are processed promptly by the state, and that an administrative appeal process is available for FQHCs to contest either the denial of a rate adjustment application or the amount of the rate adjustment. According to NACHC's 2018 state policy assessment, twelve PCAs indicated that their state provided for an administrative appeal for an adverse determination; three PCAs reported that administrative appeal was available for a state's failure to act on an application.

[6] SSA § 1902(bb)(6).

[7] Memorandum from Richard Chambers, Acting Director, Family and Children's Health Programs Group, Health Care Financing Administration (now CMS), to Associate Regional Administrators (Sept. 12, 2001), re: BIPA Section 702 PPS for FQHCs, at http://www.nachc.org/wp-content/uploads/2015/11/PPS-Q-As-2001.pdf.

[8] SSA § 1902(bb)(3)(B) (emphasis added).

A final important procedural issue is the handling of scope change rate adjustments initiated by the state. A state may initiate a rate adjustment where a service that was incorporated into some or all of FQHCs' PPS rates in the state as an "other ambulatory service" is removed from the state plan. Even where the rate adjustment is initiated by the state, health centers should still have the opportunity to submit cost reports documenting the financial impact of the change, to submit other relevant documentation, and to appeal rate adjustment decisions that they dispute.

Conclusion

Scope change rate adjustments are the main mechanism that ensures that the PPS used to pay FQHCs under Medicaid is a dynamic methodology reflecting the range of services that each health center currently provides. The process is inherently complex—both because a wide range of events can qualify as a "change in the scope of services," and because the FQHC must prepare and submit (and the state must evaluate) cost reports in order to document the impact of the change. FQHCs and PCAs should consider whether their state's rate adjustment policies include the features described in this issue brief and if needed, work with their state to explore improvements in state policies.

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