MEMORANDUM

TO: **Lisa Cruz Hidrogo, CTCM**
Special Projects Manager
Texas Health and Human Services Commission

FROM: **José E. Camacho**
Executive Director and General Counsel
Texas Association of Community Health Centers

DATE: **April 12, 2018**

SUBJECT: **Federally Qualified Health Center (FQHC) Wrap Payment Methodology**

Thank you for meeting with us on April 3, 2018. I appreciate the fact that FQHCs are being given the opportunity to respond before any steps are taken to undo the recently implemented wrap payment methodology or impose prior approval requirements on out-of-network services.

ISSUE ONE: WRAP PAYMENT METHOD

Background: As outlined in the attached Wrap Timeline, the FY 2012-2013 budget granted the Health and Human Services Commission (HHSC) the authority to "…include provisions for payment of the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) rate and establish contractual requirements that Managed Care Organizations (MCOs) reimburse FQHCs at the PPS rate." That Rider: FQHC Reimbursement in Managed Care was removed from the budget effective September 1, 2017. On September 1, 2017, HHSC implemented a new PPS wrap payment methodology for Medicaid and CHIP, medical and behavioral health services, and on March 1, 2018 for dental services. This new PPS methodology reverted to the methodology previously approved by **ALL** FQHCs because of regulatory changes codified in 1 TAC, 355.8261, Federally Qualified Health Center Services Reimbursement. The corresponding State Plan Amendment received approval from the Center for Medicare and Medicaid Services (CMS) effective October 2, 2010. (See Texas State Plan Amendment TN 10-61.)

No other changes to this regulation were approved until September 1, 2017. The changes approved on September 1, 2017 were primarily administrative in nature, and did not change the basic requirement approved by FQHCs in 2010. State Plan Amendment TN 17-0002 effective September 1, 2017 described in detail how the requirements of 1 TAC 355.8261 (b)(11) were to be implemented. This new FQHC wrap payment methodology described the state's process for calculating its supplemental payment. Most importantly, all FQHCs, MCOs, and the state collaboratively developed and approved the new regulation.

Issue: On April 3, 2018 HHSC informed FQHC representatives that it would revert to the PPS/APPS payment methodology in place on August 31, 2017.

Response: HHSC no longer has the legislative authority to revert to payment methodology in place prior to September 1, 2017.

1) Per CMS letter April 26, 2016, a state can only change its FQHC payment methodology if there is agreement from all FQHCs to the change. Previous Alternative Prospective Payment System Methodology (APPS) agreements do not extend to specific future Alternative Payment Methodology (APM) changes.

2) HHSC has never received the agreement of all FQHCs for the Alternative Payment Methodology (APM) requiring the MCOs to pay the PPS/APPS which was in effect from September 1, 2011 to August 31, 2017. Furthermore, FQHCs have only previously approved the APMs outlined in the regulations approved effective October 2, 2010 and September 1, 2017.

ISSUE TWO: OUT OF NETWORK PAYMENT/WAIVING PRIOR AUTHORIZATION

Issue: HHSC is considering ending reimbursement for all FQHC out-of-network (OON) claims. This would impact all claims without prior authorization, including urgent care visits, after-hours visits, and other out-of-network visits.

Response: Texas has implemented 42 U.S.C. §1396b(m)(2)(A)(vii) by defining the category of out-of-network services for which an MCO must provide reimbursement as "emergency services." Under 1 TAC 353.4(c)(1), an MCO may not refuse to reimburse an out-of-network provider for "emergency services." The term "emergency service" is defined in 1 TAC 353.2 as "a covered inpatient and outpatient service, furnished by a network provider or out-of-network provider that is qualified to furnish such service, that is needed to evaluate or stabilize an emergency medical condition and/or an emergency behavioral health condition. For health care MCOs, the term "emergency service" includes post-stabilization care services."

Per 1 TAC 353.2, an "emergency medical condition" is a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care to result in: placing the patient's health in serious jeopardy; serious impairment to bodily functions; serious dysfunction of any bodily organ or part; serious disfigurement; or serious jeopardy to the health of a pregnant woman or her unborn child.

Under federal law, FQHCs are required to provide care to ANY patient that presents at the FQHC, including patients presenting after hours [42 U.S.C., Section 330(k)]. Per Section 533.005 (14) of the Texas Government Code, a contract between an MCO and the Commission for the organization to provide health care services to recipients must contain a requirement that the MCO reimburse an FQHC for health care services provided to a recipient outside of regular business hours, including weekends and federal holidays at a rate equal to the allowable rate for those services i.e. the FQHC's PPS rate. "Outside of regular business hours" (after-hours care) is defined in the 4.1.2 of the Clinics and Other Outpatient Facility Services Handbook in the Texas Medicaid Provider Procedure Manual as care provided on weekends, on federal holidays, or before 8 a.m. and after 5 p.m. After-hours care provided by FQHCs does not require a referral. The overwhelming number of claims for after-hours services provided by FQHCs are not classified as urgent or emergency services.

RESOLUTION

FQHCs propose to sign the attached Prospective Payment System Approval Form to evidence that they approve the payment methodology as was implemented on September 1, 2017, but not subsequent changes to it. TACHC requests a follow-up meeting with Commission staff to discuss continuance of the current methodology, including out-of-network payments as proposed in the form, before any further actions are taken.