Proposed Comprehensive Reimbursement Structure for Federally Qualified Health Centers and Rural Health Clinics

Session Law 2022-74, Section 9D.8.(c)

Report to

Joint Legislative Oversight Committee on Medicaid and NC Health Choice

The Fiscal Research Division

By

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Executive Summary

Pursuant to Section 9D.8.(c) of Session Law (S.L.) 2022-74, in partnership with the North Carolina Community Health Center Association (NCCHCA), the North Carolina Department of Health and Human Services (DHHS) developed a new comprehensive Medicaid reimbursement structure for Federally Qualified Health Centers (FQHCs) to addresses financial and operational challenges associated with the current approach. Since DHHS has historically reimbursed rural health clinics (RHCs) in the same manner as FQHCs, it intends to apply this proposed methodology to both FQHCs and RHCs.

Current Methodology. Currently, most FQHCs/RHCs are reimbursed using a retroactive cost-settled methodology, which is designed to reimburse each FQHC/RHC at 100 percent of allowable medical, dental, and pharmacy costs. Pursuant to additional, one-time appropriations under S.L. 2022-74, in State Fiscal Year (SFY) 2022-2023, DHHS increased FQHC reimbursement to 113 percent of cost.[1] Under the current methodology, interim payments are made to FQHCs/RHCs throughout the year and are then retroactively reconciled to a final payment amount based on actual FQHC/RHC costs. In managed care, Prepaid Health Plans (PHPs) are financially at risk for and facilitate interim payments to FQHCs/RHCs, and DHHS is responsible for any necessary wraparound payments up to the cost-settled rate to FQHCs/RHCs at reconciliation.

The current methodology has a number of challenges, including (1) unpredictable cash flow for FQHCs/RHCs, because interim payments often differ substantially from actual costs; (2) inadequate pharmacy reimbursement; and (3) significant administrative burden for FQHCs/RHCs and DHHS.

Proposed Methodology. Effective July 1, 2023, DHHS proposes transitioning to a prospective cost-based approach, where FQHCs/RHCs receive a per-encounter rate equal to 113 percent of each FQHC's/RHC's historical allowable medical and dental costs, adjusted annually to account for inflation. Unlike in the current methodology, pharmacy costs would be excluded from the encounter rate and reimbursed separately based on actual acquisition costs and a dispensing fee. PHPs would reimburse FQHCs/RHCs for the full encounter rate; however, they would be at financial risk for only a portion of the encounter rate comparable to that of non-FQHC/RHC primary care providers.

Under the proposed approach, FQHCs/RHCs would receive the full encounter payment at, or soon after, initial claims adjudication, and there would be no retroactive cost settlement. As a result, the approach would establish more predictable cash flows to FQHCs/RHCs, and by eliminating the retroactive cost settlement would substantially minimize administrative burden. Additionally, reimbursing pharmacy services outside of the encounter rate would ensure predictable

[1] Pursuant to section 9D.8.(b) of S.L. 2022-74, DHHS implemented an effective 13 percent rate increase for FQHCs in SFY 2022-2023.

reimbursement for ingredient and dispensing costs. Finally, incorporating the 13 percent rate enhancement on a permanent basis would allow FQHCs/RHCs to invest in programs and services that expand access to care for medically underserved populations.

Estimated Costs. The estimated incremental costs for SFY 2023-2024 are displayed below.

Entity Type	Non-Federal Share Only	Total Computable Cost
FQHCs	$4,368,025	$12,992,299
RHCs	$877,834	$2,611,037

Introduction

Pursuant to Section 9D.8.(c) of Session Law (S.L.) 2022-74, the North Carolina Department of Health and Human Services (DHHS) is submitting this report on a proposed comprehensive reimbursement structure for federally qualified health centers (FQHCs) to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division.

In July 2022, the North Carolina General Assembly enacted S.L. 2022-74, which (1) appropriated $4,400,000 in nonrecurring State General Fund dollars for temporary Medicaid reimbursement increases to FQHCs and (2) directed DHHS to collaborate with FQHCs to develop a comprehensive Medicaid reimbursement structure that addresses pharmacy costs in the context of overall financial challenges faced by FQHCs. DHHS proposes to implement this revised reimbursement methodology at the start of State Fiscal Year (SFY) 2023-2024. Since DHHS has historically reimbursed rural health clinics (RHCs) in the same manner as FQHCs, it intends to apply this proposed methodology to both FQHCs and RHCs.

Under Section 9D.8.(c) of S.L. 2022-74, DHHS is required to submit to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice of the North Carolina General Assembly and the Fiscal Research Division a "detailed proposal of the comprehensive reimbursement structure, including the anticipated cost to the State of implementation." As such, this report has the following components:

1. About FQHCs and RHCs
2. Policy Goals of FQHC/RHC Medicaid Reimbursement Proposal
3. Federal Payment Parameters
4. Current Reimbursement Methodology
5. Proposed Reimbursement Methodology
6. Estimated Cost of Implementation
7. Rationale for Key Changes to Methodology
8. Implementation Plan

This report was developed in close collaboration with the North Carolina Community Health Center Association (NCCHCA) and in consultation with North Carolina's RHCs. DHHS looks forward to continued collaboration with the General Assembly, NCCHCA, RHCs, and other stakeholders to develop and implement a new reimbursement approach.

1. About FQHCs and RHCs

FQHCs[2] and RHCs[3] are federally designated provider types established to facilitate access to care in medically underserved areas. FQHCs are nonprofit or public providers that are required to serve all individuals, regardless of their ability to pay. RHCs are similar to health centers but, among other differences, operate only in designated rural areas and may be operated by for-profit entities.

FQHCs and RHCs are critical components of North Carolina's safety net and Medicaid health care delivery systems, addressing both geographic and financial access barriers. Moreover, research suggests that health centers, including FQHCs, primarily serve Medicaid and uninsured populations, improve patient health outcomes, and reduce costs.[4]

2. Policy Goals of FQHC/RHC Medicaid Reimbursement Proposal

DHHS and NCCHCA identified the following policy goals to guide development of the comprehensive reimbursement structure:

- Maintain beneficiary access to FQHC/RHC providers and services;
- Address concerns that rate differentials between FQHCs/RHCs and other primary care providers could incentivize Prepaid Health Plans (PHPs) to steer utilization to non-FQHC/RHC providers due to their lower rates;
- Promote a level playing field for FQHCs/RHCs and other providers in negotiating value-based purchasing (VBP) arrangements with PHPs;
- Ensure timely cash flow to FQHCs/RHCs;
- Minimize administrative burden for FQHCs/RHCs; and
- Align the payment methodology across fee-for-service (FFS) and managed care delivery systems to the extent possible.

[2] As defined in 42 U.S.C. 1396d(l)(2)(B).

[3] As defined in 42 U.S.C. 1395x(aa)(2).

[4] Congressional Research Service. *Federal Health Centers: An Overview* (R43937), prepared by Elayne J. Heisler. May 19, 2017. https://crsreports.congress.gov/product/pdf/R/R43937

Combined, these policy goals served as a framework guiding the development of the reimbursement proposal.

3. Federal Payment Parameters

Medicaid payments to FQHCs/RHCs are governed by federal statutes, namely the Social Security Act, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)[5] and implemented by the Centers for Medicare & Medicaid Services (CMS).[6] Under federal law, states must reimburse FQHCs/RHCs using the prospective payment system (PPS), a per-encounter rate methodology based on each FQHC's/RHC's costs from fiscal years 1999 and 2000 and increased annually thereafter to account for inflation. In addition to the PPS, federal law permits state Medicaid programs to develop alternative payment methodologies (APMs), so long as doing so results in payments at least equal to the amount that would have otherwise been paid under the PPS.[7] Where an APM is established, FQHCs/RHCs may choose between the federal PPS or the state-established APM.

In the Medicaid managed care context, federal law does not require Medicaid managed care organizations (MCOs) to reimburse FQHCs/RHCs at the PPS or APM rate (unless otherwise required by the state); instead, MCOs must pay at least what they would pay non-FQHC/RHC providers for similar services.[8] When aggregate managed care payments to an FQHC/RHC are less than the PPS amount, state Medicaid programs are required to make supplemental "wraparound" payments to cover the difference between the contracted rate paid by the MCOs and the PPS rate.[9]

4. Current Reimbursement Methodology

4.1 Key Components of Current Methodology

Encounter Rate Methodology. As described in the State Plan,[10] FQHCs/RHCs currently choose from three encounter rate methodologies—(1) the federal PPS rate methodology; (2) an APM using a PPS-like encounter rate based on the individual FQHC's/RHC's 2018 costs and inflated annually by the Medicare Economic Index; or (3) an APM using the greater of the second methodology or a retroactive cost-settled encounter rate, which is designed to reimburse each

[5] 42 U.S.C. § 1396a(bb).

[6] Since BIPA's enactment, CMS has issued subregulatory guidance related to FQHC reimbursement in Medicaid and the Children's Health Insurance Program (CHIP), including a Q&A (September 12, 2001) and two State Health Official letters, SHO #10-004 (February 4, 2010) and SHO #16-006 (April 26, 2016).

[7] 42 U.S.C. § 1396a(bb)(6).

[8] 42 U.S.C. § 1396b(m)(2)(A)(ix).

[9] 42 U.S.C. § 1396a(bb)(6).

[10] As approved in State Plan Amendment (SPA) #22-0022.

FQHC at 100 percent of its allowable costs[11] for Medicaid services, including medical, dental, and pharmacy. The majority of FQHCs and RHCs are reimbursed via the retroactive cost-settled APM. For SFY 2022-2023, DHHS increased aggregate FQHC reimbursement levels by a total computable amount of $14,906,354 (non-federal share of $4,400,000), as enacted in section 9D.8.(b) S.L. 2022-74, an effective 13 percent rate enhancement.

Encounter Criteria. DHHS defines two types of FQHC/RHC services—encounters and other ambulatory services.

- **Encounters** are face-to-face visits between a patient and any FQHC/RHC health professional whose medical and dental services are reimbursed under the State Plan, and are operationalized using a defined set of service codes eligible for reimbursement at the encounter rate.
- **Other ambulatory services** delivered by FQHCs/RHCs, such as durable medical equipment, laboratory services, and pharmacy, are considered incidental to the encounter. While "incidental" services are not considered encounters, their costs are accounted for in each FQHC's/RHC's encounter rate.

Claims Adjudication. In both managed care and FFS, FQHCs/RHCs receive three types of interim payments upon claims adjudication. Payments upon claims adjudication are made on an interim basis to support an FQHC's/RHC's cash flow prior to the annual reconciliation process, then the FQHC's/RHC's final reimbursement is calculated based on its PPS or APM rate.

- ***Encounters.*** Medical services classified as an encounter are initially paid at the Core Service rate (T1015),[12] which is meant to approximate each FQHC's/RHC's PPS or APM rate less estimated initial reimbursement for other ambulatory services and pharmacy, described below.
- ***Other Ambulatory Services.*** All other ambulatory claims are initially paid based on State Plan approved fee schedules comparable to Medicaid rates for non-FQHC/RHC providers.

[11] Due to challenges with the FQHC/RHC cost reporting methodology, FQHCs/RHCs with pharmacies are often reimbursed at less than 100 percent of cost for pharmacy services. This is described in more detail on pages 7-8.
[12] The Core Service rate (T1015) is an interim payment rate that is established for each FQHC/RHC using FY 2018 cost reports. The Core Service rate is intended to minimize the level of reconciliation required to reach final reimbursement levels at the applicable encounter rate.

- ***Pharmacy.*** Pharmacy claims are initially paid at acquisition cost levels with a dispensing fee.[13,14,15,16]

PHP Capitation Rate Development. In managed care, PHPs are required to make these interim payments using the Medicaid FFS interim payment methodologies described above. PHPs are at financial risk for all three interim payments; that is, they are all included in prospective PHP capitation rates.

Reconciliation. DHHS reconciles each FQHC's/RHC's interim payments to the FQHC's/RHC's selected PPS or APM rate,[17] with slightly different methodologies for FFS and managed care.

- ***FFS.*** Annually, DHHS reconciles each FQHC's/RHC's interim payments up *or* down to the applicable PPS or APM rate. In this reconciliation process, DHHS (1) tabulates the total number of encounters in FFS, (2) multiplies the total number of FFS encounters by the PPS or APM rate, and (3) subtracts all interim FFS payments received. If an FQHC's/RHC's total interim payments are less than reimbursement under the applicable PPS or APM, DHHS makes a wraparound payment to the FQHC/RHC for the difference. However, if an FQHC's/RHC's interim payments exceed reimbursement under the applicable PPS or APM, DHHS recoups the difference (i.e., FQHCs/RHCs make a payment back to DHHS). The latter scenario can occur because other ambulatory services and pharmacy, although reimbursed initially, are not considered an encounter and therefore not eligible for reimbursement at the applicable PPS or APM rate.
- ***Managed Care.*** Quarterly, DHHS reconciles each FQHC's/RHC's interim payments only *up* to the applicable PPS or APM rate, using the same methodology as under FFS. However, no recoupment occurs if interim payments exceed reimbursement under the applicable PPS or APM.

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[13] Reimbursement levels differ depending on whether the patient meets the 340B Drug Pricing Program patient definition. FQHCs are "covered entities" under the 340B Program, which provides drug discounts to certain healthcare providers delivering care to low-income and uninsured patients. Based on federal requirements, FQHCs and other covered entities can only receive discounts for drugs dispensed to patients with which they have an established relationship. While FQHCs dispense most drugs to individuals that meet the 340B patient definition, some FQHCs operate pharmacies that are open to members of the public who are not otherwise patients of the FQHC. In such cases, FQHCs are reimbursed for medications dispensed to 340B-eligible individuals at 340B acquisition cost, and medications dispensed to non-340B eligible patients at the non-340B State Plan approved rate.

[14] Office of Pharmacy Affairs (OPA), Health Resources & Services Administration (HRSA). *340B Drug Pricing Program.* Retrieved January 18, 2023. https://www.hrsa.gov/opa

[15] U.S. Government Accountability Office. *Drug Pricing Program: HHS Uses Multiple Mechanisms to Help Ensure Compliance with 340B Requirements* (GAO-21-107). December 14, 2020. https://www.gao.gov/assets/gao-21-107.pdf

[16] Congressional Research Service. *Overview of the 340B Drug Discount Program* (IF12232), Prepared by Hannah-Alise Rogers. October 14, 2022. https://crsreports.congress.gov/product/pdf/IF/IF12232

[17] Consistent with 42 U.S.C. § 1396a(bb)(6), DHHS ensures that all FQHCs/RHCs receive at least the PPS rate.

4.2 Challenges with Current Methodology

The cost-settled APM, the most commonly used methodology, presents a number of challenges to FQHCs/RHCs.

- ***Inadequate Pharmacy Reimbursement.*** The cost allocation methodology, which drives the cost-settled APM and annual reconciliation, identifies each FQHC's/RHC's Medicaid pharmacy costs based on the share of pharmacy claims attributable to Medicaid beneficiaries, rather than actual acquisition costs and dispensing fees of Medicaid pharmacy claims. As a result, FQHCs/RHCs that care for Medicaid beneficiaries who utilize costly specialty drugs at greater rates than the FQHC's/RHC's patients with other coverage (i.e., Medicare, commercial, uninsured) often receive reimbursement that is substantially less than cost.
- ***Administrative Burden.*** FQHCs/RHCs (and DHHS) experience significant administrative burden associated with annual cost reporting and year-end reconciliation processes.
- ***Unpredictable Cash Flow.*** FQHCs/RHCs with a cost-settled APM can experience unpredictable cash flow since cost-settled wraparound payments are calculated only annually and the magnitude of wraparound payments can be unpredictable. Further, if total FFS interim payments for the year exceed final PPS or APM reimbursement levels, FQHCs/RHCs must make a payment equal to the difference back to DHHS.
- ***PHP Steerage Incentive.*** Because FQHC/RHC reimbursement rates are higher than "market-based" rates of other primary care providers, an adverse incentive may exist for PHPs to steer utilization to lower-cost providers.
- ***VBP Contracting Limitations.*** As noted above, interim payments to FQHCs/RHCs are higher than payments made to other primary care providers. As a result, it can be difficult for FQHCs/RHCs to meaningfully participate in shared savings arrangements offered by PHPs, which often use a standardized cost benchmark applicable to all primary care providers with no adjustments to account for higher per-service FQHC/RHC payment levels.

5. Proposed Reimbursement Methodology

Under the proposed approach, FQHCs/RHCs would choose between the federal PPS and a new State-developed APM. This section describes the key components of the new APM and illustrates how funds flow among DHHS, PHPs, and FQHCs/RHCs *(see Appendix Figure 2)*.

5.1 Proposed APM Methodology in Managed Care

Rate Methodology. The proposed design establishes a cost-based APM using an FQHC/RHC-specific, prospective, per-encounter rate. The APM rate is based on each FQHC's/RHC's historical

allowable costs[18] with a 13 percent rate enhancement, consistent with the effective 13 percent rate enhancement applied to FQHC/RHC reimbursement levels in SFY 2022-2023. As described below, the APM would include historical medical and dental costs and would govern reimbursement for both service types. However, pharmacy costs would be carved out of the APM rate and reimbursed separately based on actual 340B acquisition costs plus a dispensing fee. DHHS will set each FQHC's/RHC's SFY 2023-2024 APM encounter rate as follows:

- ***Identify the Average Cost per Encounter.*** Based on the FQHC's/RHC's most recently available cost report, divide the total allowable costs less pharmacy by the total number of encounters.
- ***Inflate the Average Cost per Encounter.*** Multiply the average cost per encounter by an inflation factor[19] to trend the figure to the applicable SFY.
- ***Apply the Rate Enhancement.*** Multiply the inflated average cost per encounter by 1.13 to apply the 13 percent rate enhancement.

To account for inflation in future years, DHHS will adjust the APM rate annually in one of two ways *(see Appendix Figure 1)*:

- ***Rebase APM Rates.*** DHHS will rebase APM rates *every three years*, meaning DHHS will recalculate the APM rate, as described above and shown in Appendix Figure 1, using updated cost report data. *FQHCs/RHCs will only be required to submit cost reports during rebasing years.*[20]
- ***Inflate APM Rates.*** In SFYs when the APM rate is not rebased, DHHS will inflate the prior SFY's APM rate by the greater of either the Medicare FQHC Market Basket or CPI for medical care.

Encounter Criteria. DHHS will continue to use the current criteria to define which services constitute an encounter and are eligible to receive the APM encounter rate. "Incidental" ambulatory services, however, will not receive separate reimbursement, since payment for these services is included in the APM rate.

PHP Capitation Rate Development. Under the proposed methodology, PHPs and FQHCs/RHCs will negotiate initial per-encounter payment rates, subject to a rate floor established by DHHS. This negotiated rate is intended to mirror a market-based rate, comparable to that of non-FQHC/RHC providers rendering similar services.[21] PHPs are financially at risk for the market-based rate and

[18] The APM encounter rate for SFY 2023-2024 would be based on FY 2021 cost reports.

[19] Apply the greater of either the Medicare FQHC Market Basket or Consumer Price Index (CPI) for medical care.

[20] Except where an FQHC/RHC requests a change in scope of services, in which case a cost report is required.

[21] In compliance with 42 U.S.C. § 1396b(m)(2)(A)(ix).

the cost of pharmacy reimbursement, but not the full APM encounter rate, which will be paid as a wraparound payment *(see Claims Adjudication below)*.

Claims Adjudication. PHPs will pay FQHCs/RHCs as follows:

- ***Initial Negotiated Rate Payment.*** PHPs will make initial payments to FQHCs/RHCs at the negotiated rate, for which PHPs are financially at risk.
- ***Supplemental Wraparound Payment.*** On at least a monthly basis,[22] PHPs will make supplemental wraparound payments to FQHCs/RHCs equal to the FQHC's/RHC's APM rate, less initial negotiated payments already made by the PHP.
- ***Pharmacy Claims Payment.*** PHPs will pay FQHCs at the State Plan approved level of acquisition cost and a dispensing fee.

Reconciliation. DHHS will reimburse PHPs for the total amount of supplemental wraparound payments made to FQHCs/RHCs. Unlike in the current methodology, no additional reconciliation between DHHS and FQHCs/RHCs is required.[23,24]

5.2 Proposed APM Methodology in Fee-for-Service (FFS)

DHHS will continue reimbursing some services in FFS, including all services for populations excluded[25] from Medicaid managed care enrollment and dental services,[26] which are carved out of managed care. FQHC/RHC reimbursement in FFS generally follows the same methodology and processes as in managed care, with FQHCs/RHCs being reimbursed for eligible encounters using the APM rate; however, claims adjudication processes differ. For non-dental claims, DHHS would pay the full encounter rate directly to FQHCs/RHCs. For dental services, because DHHS does not have service codes that can be used to identify qualifying dental encounters, DHHS would

[22] DHHS will require PHPs to make wraparound payments at least monthly for at least six months following implementation of the new methodology. Then, DHHS' goal is to transition to real-time wraparound payments, where PHPs would reimburse FQHCs/RHCs for both the negotiated rate and wraparound payments upon initial claims adjudication.

[23] Per CMS guidance (SHO #16-006), DHHS will continue its oversight processes to ensure that the managed care payments comply with the statutory requirements of the APM.

[24] Consistent with 42 U.S.C. § 1396a(bb)(6), DHHS ensures that all FQHCs/RHCs receive at least the PPS rate.

[25] Excluded populations include beneficiaries who are receiving limited benefits (e.g., Family Planning or Emergency Only Services), medically needy, participating in the Health Insurance Premium Payment (HIPP) program, participating in the Program of All-Inclusive Care for the Elderly (PACE), children in foster care, children receiving adoption assistance, former foster youth, children receiving Community Alternatives Program for Children (CAP/C) services, children receiving Community Alternatives Program for Disabled Adults (CAP/DA) services, and people receiving both Medicaid and Medicare but not Innovations or TBI waiver services. Federally recognized tribal members and other individuals who qualify for Indian Health Services are enrolled in NC Medicaid Direct or the ECBI Tribal Option by default, but may opt into Standard or Tailored Plans where eligible.

[26] Excludes a limited subset of preventive dental services that are considered part of the Well Child medical visit and paid in managed care.

reimburse FQHCs/RHCs using an initial claims payment with a reconciliation to the encounter rate, as described below *(also see Appendix Figure 3)*:

- ***Initial Claims Adjudication.*** Upon initial claims adjudication, DHHS makes an interim payment to FQHCs/RHCs for dental claims based on a fee schedule.
- ***Encounter Tabulation.*** DHHS tabulates the total number of dental encounters by retroactively reviewing claims data and procedure billing codes. Dental encounters are limited to one beneficiary per day per FQHC/RHC, regardless of the volume of services provided. (This proposed approach makes no change to how DHHS tabulates FQHC/RHC dental under the current state.)
- ***Supplemental Wraparound Payment Calculation.*** On a quarterly basis, DHHS calculates the supplemental wraparound payment amounts owed, if applicable, to each FQHC/RHC. The supplemental wraparound payment amounts are calculated by (1) multiplying the total number of dental encounters by the FQHC/RHC-specific APM rate to get the full APM reimbursement amount, then (2) subtracting the total amount of interim dental payments already made from the full APM reimbursement amount.
- ***Supplemental Wraparound Payment Remittance.*** If the full APM reimbursement amount exceeds the interim payments already made, DHHS remits payment for the difference as a supplemental wraparound payment. If interim payments exceed the full APM reimbursement amount, meaning FQHCs received at least the full APM amount, no action is taken.

6. Estimated Cost of Implementation

The estimated cost for SFY 2023-2024 (Table 1) reflects the incremental cost associated with the proposed methodology and is primarily driven by the 13 percent rate enhancement factor. These estimates are contingent upon the General Assembly approving new appropriations to support the proposed reimbursement methodology, applicable to both FQHCs and RHCs.

Table 1: Estimated Implementation Cost of New Methodology

Entity Type	Non-Federal Share Only	Total Computable Cost
FQHCs	$4,368,025	$12,992,299
RHCs	$877,834	$2,611,037
Total	**$5,245,859**	**$15,603,336**

7. Rationale for Key Changes to Methodology

As noted in Section 3.2, both FQHCs/RHCs and DHHS experience significant administrative burden associated with the current methodology's annual cost reporting and year-end reconciliation processes. Further, FQHCs/RHCs experience additional challenges with the current methodology, including inadequate pharmacy reimbursement, unpredictable cash flow, potential for PHP steerage, and limitations in VBP contracting. Table 2 outlines the key changes[27] made to the methodology and rationale for proposing the changes.

Table 2: Rationale for Key Changes to Methodology

Methodology Component	Key Changes	Rationale
Rate Methodology	• Prospective cost-based encounter rate at 113 percent of allowable costs. • Pharmacy carved out of encounter rate and reimbursed on a per-script basis. • Rebase APM rate every three years.	• Support investment and access: Reimbursement slightly above cost allows FQHCs/RHCs to invest in programs and services for Medicaid beneficiaries and improve access to care. • Ensure predictable pharmacy reimbursement: Paying pharmacy claims outside the APM rate ensures predictable reimbursement of ingredient and dispensing costs. • Minimize administrative burden: Requiring cost reporting every three years (rather than annually) substantially reduces both FQHC/RHC and DHHS administrative burdens.
Encounter Criteria	*No change; DHHS will continue to use the same criteria to define which services constitute an encounter and which are incidental to the encounter.*	
PHP Capitation Rate Development	• PHPs are financially at risk for an initial market-based rate[28] and pharmacy claims,[29] resulting in lower prospective capitation rates compared with the current methodology.	• Minimize steerage incentive: Holding PHPs financially at risk for a market-based FQHC rate comparable to that of non-FQHC/RHC providers rendering similar services removes the financial incentive for PHPs to steer utilization away from FQHCs/RHCs to other providers. • Promote level playing field for VBP: With a market-based rate accounted for in PHP capitation and paid through initial claims adjudication, FQHCs/RHCs could participate in PHP VBP arrangements in the same way as non-FQHC/RHC providers.

[27] Encounter criteria are not included in Table 2; the same criteria will define which services constitute an encounter.

[28] PHPs and FQHCs/RHCs must negotiate initial per-encounter payment rates, subject to a rate floor in compliance with 42 U.S.C. § 1396b(m)(2)(A)(ix).

[29] PHPs must reimburse per script based on State Plan approved levels (acquisition costs, dispensing fee).

Methodology Component	Key Changes	Rationale
Claims Adjudication	• FQHCs/RHCs are reimbursed upfront (or soon thereafter) at the full encounter rate[30] rather than via interim payments with reconciliation.	• Improve cash flow: Transitioning to a prospective encounter rate enables upfront payment of the full APM rate, which makes FQHC/RHC cash flows more predictable.
Reconciliation	• For non-dental claims, the annual reconciliation process is no longer required.[31]	• Minimize administrative burden and promote stable cash flow: Eliminating the annual reconciliation process for non-dental claims provides significant administrative relief to both FQHCs/RHCs and DHHS, eliminates scenarios where DHHS must recoup payments from FQHCs/RHCs, and improves cash flow for FQHCs/RHCs that provide dental services.

8. Implementation Plan

DHHS proposes to implement this new reimbursement approach at the start of SFY 2023-2024. To do so within this time frame, DHHS must complete the following tasks:

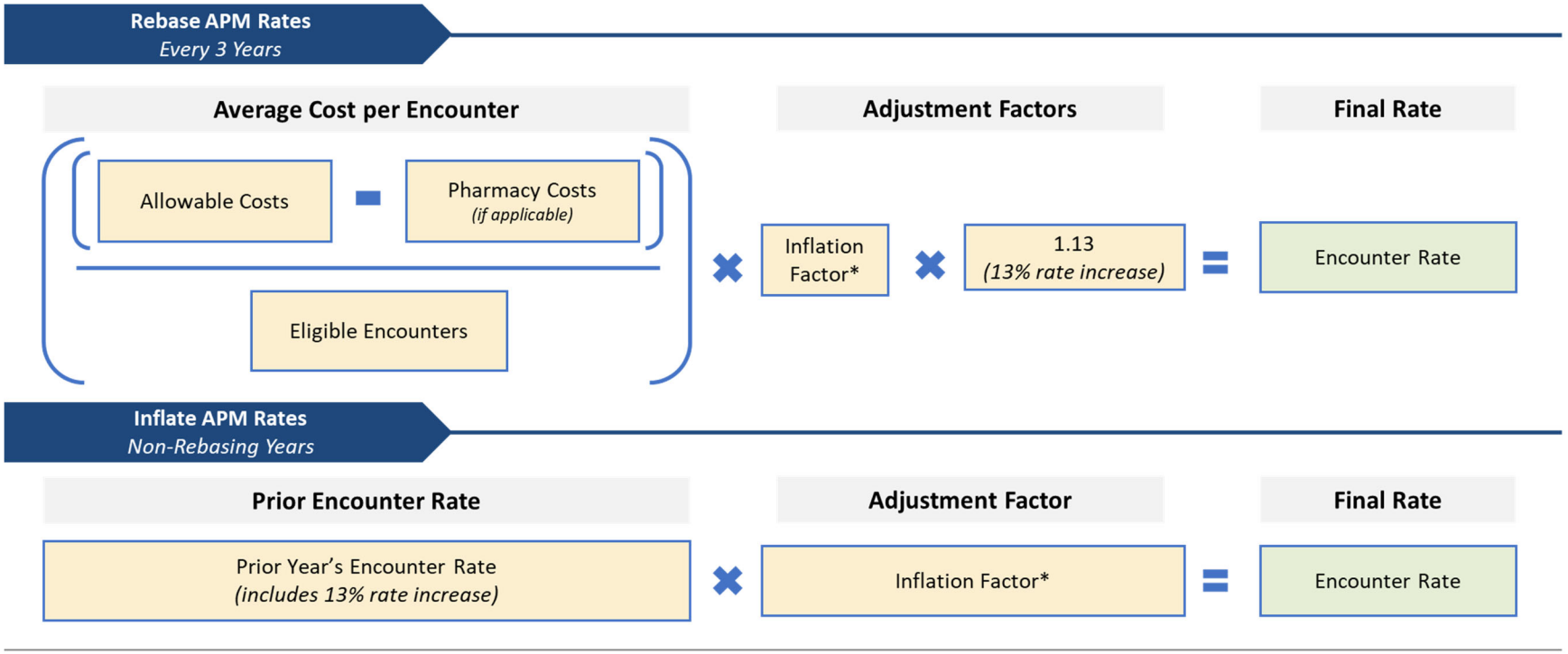
- Submit SPAs to CMS outlining the new methodology;
- Identify a PHP rate floor for initial claims payments made from PHPs to FQHCs/RHCs, and incorporate new assumptions into PHP capitation rates;
- Coordinate with PHPs, FQHCs, and RHCs to establish a process and cadence for the supplemental wraparound payment calculation and reimbursement process;
- Revise the DHHS-PHP contract to memorialize the new methodology; and
- Adjust FQHC/RHC billing guidelines based on the new methodology.

[30] As noted in Section 4.1, DHHS will require PHPs to remit wraparound payments at least monthly for at least six months before transitioning to real-time wraparound payments, where PHPs would reimburse FQHCs/RHCs for both the negotiated rate and wraparound payments upon initial claims adjudication.

[31] Consistent with 42 U.S.C. § 1396a(bb)(6), DHHS ensures that all FQHCs/RHCs receive at least the PPS rate.

Appendix

Figure 1: APM Rate Annual Inflation Adjustments



** Inflate by the greater of either the Medicare FQHC Market Basket or CPI for medical care.*

Figure 2: Managed Care Funds Flow

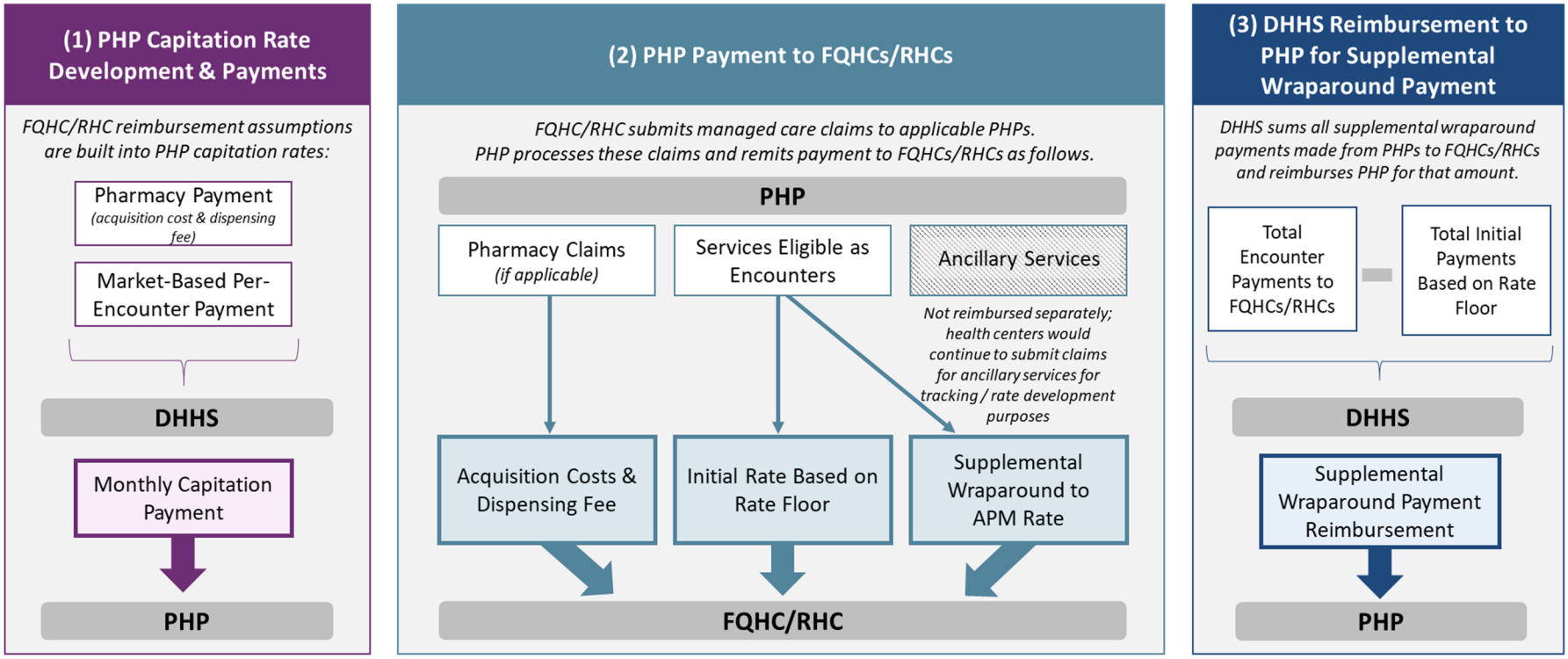


Figure 3: Dental FFS Funds Flow