January 3, 2025

Emily Ricci
Deputy Commissioner
Alaska Department of Health (DOH)
3601 C Street, Suite 902
Anchorage, Alaska 99503

By Email: Emily.ricci@alaska.gov
Re: Medicaid Payment for Federally Qualified Health Centers (FQHCs)

Dear Deputy Commissioner Ricci:

The Alaska Primary Care Association (APCA) is replying to DOH's November 5, 2024 letter and following up on our discussion of FQHC payment issues with the teams from DOH and Guidehouse Consulting on December 13, 2024.

We appreciate DOH's careful consideration of APCA's analysis and feedback on DOH's FQHC payment proposals.

APCA's central concerns described in this correspondence are the following:

(1) to provide DOH with feedback and examples as discussed in the meeting or requested by DOH concerning the scope change qualifying event definition, an interim scope change rate adjustment standard, and scope change timing and effective date provisions;
(2) to propose some modifications that would expedite or simplify the timing for new start rate-setting or change-in-scope rate adjustments under the prospective payment system (PPS);
(3) in the same vein, to seek clarification from DOH on procedures for FQHCs to elect to be paid under the APM rather than PPS methodology and to obtain APM rates; and
(4) to urge DOH to move forward promptly with scope change rate adjustments and PPS-to-APM transitions, including, if necessary, taking interim measures to ensure that pending regulatory or State plan changes do not unduly delay those processes.

Below, we respond topic by topic to DOH's November 5, 2024 letter.

"Conceptual Proposal – FQHC PPS and APM"

(A) New Start Payment Rates – Centers Newly Enrolling

APCA appreciates DOH's confirming that under DOH's proposal, interim rates for new start FQHCs would be provisional only, and the new start FQHC's final, cost-related rate would ultimately be used for payment to the FQHC for all services rendered as an FQHC dating from its enrollment in Medicaid as such.

As we understand it, DOH's proposal would be to set interim rates for new start FQHCs based on the FQHC's reasonable, vetted projection of costs per visit during the FQHC's initial operating

period, with the rate set at a maximum of 150% of the weighted statewide average of all FQHCs' encounter rates (PPS or APM).

DOH noted that the Centers for Medicare & Medicaid Services (CMS), in technical assistance feedback, had requested that a minimum also be set for the interim rate, and DOH inquired what APCA would recommend as a minimum. APCA suggests that the lowest encounter rate (PPS or APM) currently in effect in the state could be used as a minimum.

APCA inquired in our meeting with you whether under the proposed model, a new FQHC would have the option of selecting the statewide weighted average as its interim rate (as opposed to the interim rate described above, based on the FQHC's cost projection, within fixed minimum and maximum amounts). APCA recommends that the weighted statewide average remain available as an optional interim rate.

As to the final PPS rate of a new start FQHC, DOH is proposing that the PPS rate would be set based on the new FQHC's cost report in its *second full fiscal year of operation.* APCA recommends that instead, DOH compute the new FQHC's rate based on its *first two full fiscal years of operation*. We believe that the use of two years of data would result in a more accurate cost-related rate for a new FQHC, and also that the use of two fiscal years represents that most reasonable reading of the federal law, which requires that (in the absence of a center in the same or adjacent area with a similar caseload—a criterion that the parties agree typically does not apply to Alaska FQHCs), the Medicaid agency must set the new start's PPS rate using the same methodology referenced in Section 1902(bb)(2) of the Social Security Act. That methodology, in turn, relies on the use of two years of cost data. Our counsel was perplexed by the feedback DOH received from CMS to the effect that the federal statute authorizes the use of only one year of cost data for PPS rate-setting for new start FQHCs. By our read, the statute requires the opposite.

(B) New Start PPS Rates – Existing FQHCs

Alaska's twelve FQHCs that enrolled in the Medicaid program as "new starts" (twelve of Alaska's 15 FQHCs) have PPS rates that are based on statewide averages. Using a statewide average to set new start PPS rates is inconsistent with both the State plan and the Alaska regulations. (The regulations allow for the use of a statewide weighted average for new start rate-setting, but only on an initial, provisional basis.)

As discussed in our prior correspondence and in our meeting on December 13, APCA strongly urges DOH to provide for a prompt PPS rate correction or adjustment for FQHCs to ensure that their PPS rates are cost-related, as required by federal law. APCA does not support the creation of a second alternative payment methodology (APM), which would function similarly to a corrected PPS (i.e., set based on two base years' costs; inflated annually by the Medicare Economic Index (MEI)). The introduction of a new APM would only add administrative burdens for both DOH and FQHCs. The PPS rate is required to be set on a cost-related basis and to function as a floor for determining whether payment under any APM is adequate. If DOH establishes a new APM, that action would not cure the noncompliance of the existing FQHC PPS rates in Alaska.

As we stated in our letter to DOH of September 9, 2024, APCA urges DOH to correct the PPS rates that have been unlawfully set based on statewide averages by using audited cost reports for more recent years to correct the rates. APCA would support the use, for this purpose, of the base years cited in DOH's "Conceptual Proposal FQHC PPS and APM" (July 2024), which DOH planned to use as base years in establishing an alternative APM.

(C) Alternative Payment Methodology

Below, we offer comments on some of DOH's proposed modifications to its concepts for adjustments to the APM methodology.

APM inflationary adjuster. DOH has proposed to use the Medicare Economic Index (MEI) as the inflationary adjuster for the APM. APCA strongly urges DOH to use the FQHC Medicare Market Basket, as published annually by CMS, rather than the MEI. The FQHC Market Basket, first implemented for purposes of the Medicare FQHC PPS in 2017, is the only inflationary adjuster based on a market basket specifically measuring FQHCs' costs of furnishing services. The MEI is based on the costs of physician group practices, which differ significantly from FQHCs in structure, clinical requirements, and organization. Further, the FQHC Market basket is published annually by CMS, so it provides the transparency that is lacking in the current APM inflationary adjuster listed in the Alaska State plan, which is not publicly available and according to DOH, is computed on a quarterly rather than annual basis.

Further, since an APM is required to result in payment more generous than payment under the PPS, it makes sense to use an inflationary adjuster that is more generous than the one used under the PPS. Since the implementation of the Medicare FQHC Market Basket in 2017, the percentage increase in the Market Basket has been somewhat higher than the percentage increase in the MEI each year.

The MEI is not an accurate or even approximate measure of FQHCs' annual facility cost increases; it was used in the initial Medicaid FQHC PPS legislation (enacted in the year 2000) only because an FQHC-specific adjuster was not available at that time. We urge DOH to use the Medicare FQHC Market Basket instead.

Year-end reports. APCA does not object to DOH's proposed requirement that FQHCs file annual cost reports regardless whether they are paid on the PPS or APM.

With respect to the "requirement that as a condition of electing into the APM that an FQHC have submitted two full fiscal years of cost data timely filed with DOH," we believe it would be unjust for DOH to implement such a requirement in a manner that prevents FQHCs from promptly transitioning from PPS to APM (if the FQHC makes that election) for the sole reason that DOH has not had formal cost reporting and cost report review requirements for FQHCs in effect up to present. Given that DOH has not routinely collected annual cost reports from FQHCs up to present, a rule requiring two years of timely submitted cost reports in order to transition from PPS to APM would effectively penalize FQHCs for DOH's failure to implement cost report policies. Instead, we recommend that if DOH intends to make two years of timely filed cost reports a prerequisite for an FQHC to elect to be paid under the APM, then that requirement should take effect only as of the third fiscal year following the FQHC's then-current fiscal year at the time any such regulation is promulgated.

“Conceptual Proposal – FQHC COS”

(A) Change of Scope

“Catch-up” scope change procedure. APCA has argued that DOH implement a “catch-up” change-in-scope procedure to ensure that FQHCs have the opportunity to have their PPS rates adjusted to reflect qualifying scope change events that occurred in recent years, but before DOH’s anticipated implementation of a formal change-in-scope policy. We believe such a catch-up mechanism is essential in order to uphold DOH’s obligations under federal law, given that the Social Security Act required health centers’ PPS rates to be adjusted to reflect changes in the scope of services beginning in 2001, and DOH has to date never implemented a formal mechanism for health centers to seek scope change rate adjustments.

APCA appreciates DOH’s expressed willingness to continue to evaluate this request. In fact, Alaska is *already required by its existing State plan and regulations* to process scope change rate adjustments as required by federal law. Nothing in federal law forecloses DOH from allowing FQHCs an opportunity to obtain rate adjustments to reflect the impact of changes in the scope of services that their organizations experienced in years predating the implementation of a formal scope change review process. If DOH institutes policies that pose barriers to FQHCs receiving adjusted PPS rates for a multi-year period due to reporting and effective date timelines, such policies effectively extend the period of DOH’s noncompliance with federal law on this issue.

APCA would like to commend to your attention example language in an approved State plan providing for more lenient reporting timeframes for scope changes that occurred during fiscal years preceding a State’s implementation of formal scope change procedures. California’s State plan pages setting forth formal scope change provisions were approved effective July 1, 2005; however, the federal PPS statute requires that the impact of scope changes occurring on or after the first day of fiscal year 2001 be reflected in a center’s PPS rate. (See SSA § 1902(bb)(2), (4).) The California State plan therefore, following a provision that sets forth deadlines for submission to the agency of a change-in-scope rate adjustment application, provided:

> Notwithstanding paragraph K.4, if the approved scope-of-service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope-of service change, the adjusted reimbursement rate for that scope-of-service change will be made retroactive to the date the scope-of-service change was initially implemented. Scope-of-service changes under this paragraph must be submitted within 150 days after the adoption and issuance of the written instructions by OHS.[1]

We believe that such an interim provision is essential in order for DOH to comply with the law requiring states to adjust PPS rates for changes in the scope of services.

[1] California State Plan, Att. 4.19-B, Section K.5 (page 6O)

Definition of "change in the scope of services." DOH requested an example of a definition of an event qualifying as a "change in the scope of services" that APCA would recommend as compliant with federal requirements.

As an initial matter, we recommend that DOH incorporate as its basic "qualifying event" definition, the language used in the 2001 CMS guidance, which specifies that a change in the scope of services corresponds to a change in the "type, intensity, duration, or amount" of FQHC services.

We would also support a decision by DOH to include a bullet-point illustrative list of potential types of scope changes. However, we would recommend that such a list not be considered an exclusive list of types of events that would qualify as a change in the scope of services, but instead, be worded as a list of examples. A model for such a non-exclusive list of bullet-point examples can be found at Section K.2 of California's FQHC payment State plan amendment (Att. 4.19B, pp. 6M-6O.) The California State plan language, while it includes a fairly robust list of scope change examples, was developed more than twenty years ago. Therefore, we believe it would benefit from supplementation to take into account some more recent innovations that, if their cost impact meets the threshold, should qualify as scope changes (such as implementation of electronic practice management systems, patient-centered medical homes, etc.). We would recommend supplementing the list with several items from Washington Health Care Authority's *Federally Qualified Health Centers (FQHC) Billing Guide,* pp. 42-43 (https://www.hca.wa.gov/assets/billers-and-providers/FQHC-bg-20240401.pdf). We have attached with this letter a proposed definition, which is based on a combination of those two authorities.

Use of a change-in-scope cost threshold. DOH proposes to adjust the cost change threshold percentage of 5 percent in its initial correspondence, to three percent. APCA appreciates DOH's willingness to reevaluate this issue; however, we emphasize that the Alaska scope change regulations currently contained in the state code, which have never been formally implemented by DOH, require a 2.5 percent threshold. (See 7 AAC § 145.700(f).)

A threshold of 2.5% would be more consistent with state practices around the country than the 3% threshold that DOH proposes to use. Given that Alaska is implementing a working scope change policy for the first time almost 25 years after the requirement took effect, we believe it would best advance the goal of implementing a workable scope change process for DOH to use, at maximum, the threshold percentage stated in Alaska's existing regulations.

As your team noted in our December 13 meeting, the use of a percentage threshold is ultimately a materiality test—i.e., what level of cost impact of a scope change is significant enough to warrant the resource expenditure involved in processing the scope change request? We believe a 2.5 percent change (for example, a post-scope-change cost per visit that is $10 higher than an existing $400 per-visit rate) is significant enough to warrant a rate adjustment.

Prospective scope changes. As we have stated in our prior correspondence, APCA objects to the removal of an option to seek a scope change rate adjustment prospectively. This option exists

under the current State regulations, which have never been operationally implemented. The use of a prospective scope change option provides predictability for both FQHCs and the Department.

APCA believes it is inconsistent with the goals of making the scope change process more accessible and effective, for DOH to propose a process that is *more restrictive than the one described in the current state regulations*. In general, it is the norm across the country for states to allow a prospective option for FQHCs to seek an interim rate adjustment where an upcoming change in the service delivery is anticipated.

Effective date for changes in the scope of services. Under DOH's draft policy, rate adjustments would take effect on the first day of the provider's fiscal year following the year in which the scope change event occurred. Further, a scope change would be deemed to *occur* in the year including twelve full months of cost experience associated with the change.

These policies, in combination, result in a violation of the federal requirements regarding the effective dates for scope change rate adjustments. The federal law federal at section 1902(bb)(3) requires that the PPS rate for each fiscal year take into account any changes in the scope of services occurring in the previous fiscal year. The law requires that the PPS rates for any given year reflect the rates for the "preceding fiscal year," "adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic *during that fiscal year*." Social Security Act § 1902(bb)(3)(B) (emphasis added). Further, CMS guidance on scope change rate adjustments explicitly states: "Adjustments for increases/decreases in the scope of services are reflected in the PPS rate for services provided in the fiscal year following the year in which the change in scope of services took place."[2]

Cumulatively, the policies DOH has proposed unduly prolong the scope change process. As an example, consider an FQHC with a fiscal year ending September 30. If the FQHC opens a new service line effective November 1, 2025, then the FQHC's first full year of cost experience including the change would be FY2027 (i.e., the fiscal year encompassing 10/1/2026-9/30/2027). Per DOH's draft policy, the rate adjustment for such an FQHC would take effect the first day of the subsequent year—i.e., October 1, 2027. This would be almost two years after the new service line was implemented. The effect would be that the FQHC would continue to receive payment, for two years after the qualifying event, under a PPS rate that does not take into account the costs associated with the new service. It is unlawful and unreasonable to impose a 2-year time lag between the occurrence of a scope change event and the effective date of an adjusted rate.

APCA strongly urges DOH to amend its proposal to provide for an effective date of either (1) for discrete events (e.g., the addition of a new service line), the date of implementation of the change; or (2) for other events, the first day of the fiscal year following the year when the scope change began. If DOH wishes to compute a final adjusted rate based on a fiscal year reflecting twelve full months of

[2] Memorandum from Richard Chambers, Acting Director, Family & Children's Health Programs Group, HCFA, to HCFA Associate Regional Administrators (Sept. 12, 2001), p. 6.

cost experience of the scope change, when DOH may set a provisional rate based on the cost report accompanying the FQHC's initial application. DOH could then establish a final adjusted scope change rate through a retrospective cost report review for the first year containing twelve full months of cost experience of the change.[3]

Transition from PPS to APM. DOH's correspondence to APCA has not focused on this issue, and we'd like to highlight it as an urgent issue. FQHCs that are currently paid under the PPS are receiving payments that are not compliant with requirements under federal and state law and the Alaska State plan. DOH has refused to implement any rate adjustment mechanisms that would allow for a fast-track rate change for those health centers, to acknowledge that they have not been receiving cost-related payment as required.

If DOH is maintaining this position, it should at minimum provide for a transparent, fast-track process for FQHCs to transition from the PPS to the APM. This should include the opportunity for the FQHC to obtain a scope change adjusted PPS rate (equal to the initial APM rate) at the time its rate methodology is transitioned, provided that the FQHC can demonstrate that it experienced qualifying scope change rate adjustment(s) in the years whose cost reports are used to calculate the initial APM rate.

Format and timeframe for policy changes. While APCA supports the policy decision to memorialize DOH's new policies in the CMS-approved State plan, we also note that nothing in the current State plan would foreclose DOH from proceeding with implementing scope change rate adjustments and new start rate-setting in the manner the parties have been discussing and issuing guidance reflecting agreed-upon solutions. In fact, DOH has been noncompliant with its State plan up to present, by using statewide averages for new start rate-setting and by having no working policy for scope change rate adjustments. We therefore request that DOH move quickly to implement the proposed policies, as follows:

- Issue (after dialogue with APCA) guidance on PPS->APM transition and immediately begin processing APM rates for centers that wish to change methodologies.
- Issue guidance regarding scope change standards, in keeping with the parties' discussions, and after issuance of that guidance, immediately begin processing scope change rate adjustments, during the timeframe while state regulations and State plan amendment(s) concerning scope changes are pending.

Outstanding issues for State plan and regulatory revision. While our present conversations have focused narrowly on three categories of issues associated with FQHC rate-setting and rate adjustment (scope change, new start rate-setting, and APM mechanics), we want to highlight that APCA's initial letter to DOH of July 2023 regarding FQHC payment issues flagged multiple provisions of the State regulations that are noncompliant with federal law or State plan provisions relating to FQHC

[3] For an example of such a policy, please see Washington Administrative Code § 182-548-1500(5)(A); Washington Health Care Authority *FQHC Billing Guide* (https://www.hca.wa.gov/assets/billers-and-providers/FQHC-bg-20241001.pdf), pp. 40-41.

payment. These provisions range from cost reporting standards, to the scope of services included within the FQHC PPS methodology.

While we appreciate the clarifications that DOH provided in our meeting of January 3, 2024 concerning DOH's procedures for reviewing FQHC cost reports and its standards for determining allowable cost centers in PPS rate-setting, it is nonetheless the case that many of the concerns about the regulations that APCA raised in the initial letter have been set aside for the time being. We urge DOH to correct provisions in the state regulations that are inconsistent with federal law or the State plan, particularly as those provisions relate to the scope of allowable service costs included within the FQHC PPS and the definition of billable visits.

APCA looks forward to working closely with DOH to address these requests in effort to provide meaningful and timely relief to Alaska FQHCs. We respectfully urge DOH to take swift action to move this work forward without delay.

Sincerely,

Nancy Merriman
CEO