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RE: *Response to Alaska Primary Care Association's (APCA) Letter Regarding Medicaid Payment for Federally Qualified Health Centers (FQHCs)*

The Department of Health (DOH) is responding to APCA's letter dated January 3, 2025 detailing the association's recommendations and concerns around Medicaid reimbursement of FQHCs. We appreciate your continued partnership and the thorough feedback provided by APCA. Below, we address each of the key points raised in your letter:

"Conceptual Proposal – FQHC PPS and APM"

(A) New Start Payment Rates – Centers Newly Enrolling

DOH recognizes the importance of establishing rates for newly enrolling FQHCs. In addition to assessing whether the rate-setting process reasonably captures costs, DOH ensures that any rates established align and comply with federal guidelines and requirements.

To determine the appropriate number of years to use in rate calculation, DOH consulted with the Centers for Medicare & Medicaid Services (CMS). CMS advised that sections 1902(bb)(3) and 1902(bb)(4) direct that the initial year's payment rate should be based on 100% of the costs incurred in furnishing services during a single fiscal year. As a result, CMS recommended that Alaska use one year of cost data rather than two for calculating the prospective payment system (PPS) rate for newly enrolling FQHCs.

Using one year of cost data not only complies with sections 1902(bb)(3) and 1902(bb)(4) and CMS guidance but also accelerates the rate-setting process. Relying on two years of data can significantly delay the establishment of cost-related payment rates, potentially causing financial uncertainty for new FQHCs. By adopting the single-year approach, DOH can implement payment rates more promptly, supporting new FQHCs in their early stages of operation.

DOH acknowledges APCA's position that two full fiscal years of data might yield a more precise cost-related rate. To that end, we encourage FQHCs to consider the Alternative Payment Methodology (APM), which has been carefully designed to capture costs accurately. Additionally, DOH has partnered with Guidehouse to conduct a rate study and gather input from FQHCs to evaluate the APM methodology and consider whether it meets the needs of service providers, or if there are opportunities for refinement.

Regarding interim rates while the final rate is being calculated, DOH appreciates APCA's request to retain the Statewide Weighted Average (SWA) as an interim rate, as well as its request to allow FQHCs to propose an alternative interim rate based on projected costs submitted to DOH. Ultimately, all interim payments will be adjusted based on the final calculated rate. Allowing FQHCs to propose an interim rate would provide greater flexibility by enabling them to select an interim rate that most closely reflects their costs and helps avoid large adjustments later.

Outlined below is a conceptual approach that would allow FQHCs to elect one of two options for their interim PPS rate:

1. SWA: Calculated using existing FQHC PPS and APM rates from a prior fiscal year.
2. Provider-Projected Costs: FQHCs could propose an interim rate by submitting projected cost data to support it. The interim rate would be subject to:
    a. A floor set at the lowest APM or PPS rate in effect during the fiscal year.
    b. A ceiling set at 150% of the SWA.

Additionally, this conceptual approach could provide for the use the first full year of cost data from the FQHC in calculating the final rate. Any regulatory change would require the State of Alaska to adopt new regulations.

(B) New Start PPS Rates – Existing FQHCs

DOH acknowledges APCA's position regarding cost-related PPS rates and your preference for avoiding the administrative burden of creating a new, secondary alternative payment methodology.

As previously stated, for all FQHCs, an updated PPS rate can still be achieved if they submit a change of scope request, and it is accepted. Once accepted, this would lead to an updated PPS rate that is more closely aligned with the FQHC's current service delivery and costs. For FQHCs who have missed the deadline for requesting a change-in-scope for prior years, DOH is working with APCA on a conceptual approach for a one-time change-in-scope adjustment catch-up, as described in more detail below. Additionally, we encourage FQHCs to consider the APM, which has been carefully designed to capture costs accurately.

(C) Alternative Payment Methodology (APM)

Below we address APCA's comments on DOH's proposed updates to the APM methodology.

APM Inflationary Adjuster

DOH appreciates APCA's feedback regarding the use of the FQHC Medicare Market Basket, as published annually by CMS, in place of the Medicare Economic Index (MEI). We note that implementing such a change requires updates to both State of Alaska regulations and Alaska's State Plan, the latter of which is subject to CMS approval.

Year-end Reports

DOH appreciates APCA's concerns regarding the annual year-end reports for FQHCs, which are required under 7 AAC 140.200(d) to be filed on or before the last day of the fifth month following the close of the fiscal year. The absence of these reports may contribute to delays in transitioning to the APM. We encourage any FQHCs that have not complied with this

requirement in previous years to submit their annual reports as soon as possible, particularly if they are interested in transitioning to the APM.

Respectfully, DOH disagrees with the assertion that it has failed to implement its regulations with respect to annual reporting. DOH has exercised discretion by not imposing the 20 percent withholding of payment, as required under 7 AAC 140.200(h), on FQHCs that have failed to submit complete annual reports in recent years. The plain language of 7 AAC 140.200(d) states "On or before the last day of the fifth month after the close of its fiscal year, *a health clinic shall file* an annual year-end report, even if the clinic did not provide medical services to recipients during that fiscal year."

DOH's decision not to penalize non-compliance reflects a deliberate effort to provide flexibility, acknowledging that annual reporting requirements—particularly for facilities that do not elect the PPS rate—can be burdensome. However, it is important to recognize that if DOH had fully enforced the reporting requirements as advocated by APCA, this would have resulted in a 20 percent withholding of payment for multiple FQHCs that did not comply with annual reporting obligations.

Moving forward, DOH urges all FQHCs to adhere to the regulatory requirements to avoid potential disruptions or delays in payment and participation in the APM.

"Conceptual Proposal – FQHC COS"

(A) Change in Scope

"Catch-Up" Scope Change Procedure.

As previously stated, we respectfully disagree with the assertion that the PPS rates for existing FQHCs were established unlawfully.

APCA has advocated for DOH to offer a "one-time opportunity to apply for a scope change rate adjustment using a reporting deadline more lenient than those included in the state regulations" (see APCA's September 9th letter to Deputy Commissioner Ricci). Currently, Alaska's regulations indicate in 7 AAC 145.700 that "a post-implementation request for a rate adjustment must be received no later than 45 days after the change in scope of services occurred." These regulations remain in effect.

DOH appreciates the collaboration with APCA regarding opportunities for a one-time adjustment. In order to evaluate this, several steps need to occur. The first step is to outline an updated definition of change in scope of services. DOH has attached a conceptual outline of this definition. The second step is for APCA to work with Guidehouse to evaluate the impact of these conceptual changes. This information is critical to evaluating the feasibility of APCA's request.

Below, we address additional relevant issues to this conceptual proposal based on our conversations with APCA.

Definition of "Change in the Scope of Services".

Thank you for providing the change of scope definition examples from California and Washington. In addition, DOH and Guidehouse have reviewed and considered the State Plan

provisions of Colorado, Mississippi, New Jersey, Oklahoma, Oregon, South Carolina, and Texas, each of which has unique definitions for changes in scope.

Based on APCA's feedback and our evaluation of these options, DOH is considering a *non-exhaustive* list of potential types of changes in scope, as outlined in the attached conceptual proposal. It is important to note that implementing any updates would require both regulatory changes and a SPA.

Use of a Change-in-Scope Cost Threshold.

DOH appreciates APCA's feedback on the change-in-scope cost threshold and already has a 2.5% in current regulation 7 AAC 145.700(f) which aligns with APCA's recommendation. DOH intends to maintain this as the change of scope threshold moving forward.

Prospective Scope Changes.

DOH appreciates APCA's feedback on prospective change-in-scope requirements and already allows for these types of requests under 7 AAC 145.700(f), provided that an FQHC delivers to DOH a one-year budget that specifies the change in scope of services, shows the projected number of visits, and provides revenue and expense projections associate with the proposed change, as required by the same regulation.

DOH intends to continue allowing for this flexibility in alignment with current regulations. DOH is working with Guidehouse and the Office of Rate Review to develop a form that FQHCs can complete and submit within the regulatory timeframe for a change in scope of services. We hope this will fully resolve some of the challenges APCA described regarding FQHC's ability to request prospective scope changes.

Effective Date for Changes in the Scope of Services.

Currently, under 7 AAC 145.700(f), if the FQHC notifies DOH before implementing a change in the scope of services, any rate adjustment will be made to coincide with the implementation date of the change. If the FQHC notifies DOH after implementing the change, any adjustment will be made to coincide with the

(A) Date of notification, for the *addition* of a category of service.

(B) Implementation date of the change, for the *deletion* of a category of service or a *change in the intensity* of a service.

DOH acknowledges APCA's request "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." We believe that our current regulations generally align with this request, with the exception that for the addition of a category of service, the effective date is based on the date of notification rather than the implementation date.

That said, DOH recognizes APCA's repeated requests for rate adjustments to be implemented as soon as possible to benefit FQHCs and their patients. Through its discussions with APCA, DOH is considering updating the effective date of rate adjustments for all changes in scope to the implementation date of the change, as requested by the FQHC, provided that the implementation date can be supported by data submitted with the change-in-scope request. If the FQHC cannot provide sufficient data to support a specific implementation date, the effective date would default to the date of notification to DOH.

With respect to the effective date of payment adjustments for any potential one-time scope change catch-up, DOH maintains that all adjustments will be prospective.

Transition from PPS to APM.

We understand APCA's desire for a transparent, fast-track transition from the PPS to APM. However, we respectfully disagree that this process has been unavailable to FQHCs. 7 AAC 145.700, as well as Alaska's CMS-approved state plan, has and continues to provide for FQHCs to enter into an agreement with DOH to receive the APM instead of the PPS. DOH has and continues to work with FQHCs to reach these agreements.

DOH is currently working with three FQHCs to conduct APM transitions as expediently as possible. Additionally, we have contracted with Myers and Stauffer to provide staffing support for rate calculations in order to expedite these transitions. If APCA is aware of other FQHCs who are interested in the transition but have not notified DOH, we would encourage those facilities to notify DOH so that we can begin the process as soon as possible.

Format and Timeframe for Policy Changes.

We respectfully disagree with the assertion that DOH has been non-compliant with its State Plan. Additionally, it is inaccurate to suggest that DOH can implement the proposed changes without updates to the State Plan and state regulations. This letter has already outlined the areas where regulatory and State Plan changes are required.

DOH does not need to issue additional guidance to implement the PPS-to-APM transition. The regulations outline the process, which remain unchanged: FQHCs must enter into an agreement with the State to receive the APM rate. The fact that a majority of FQHCs are already receiving the APM rate demonstrates that the process is functioning as intended. The Office of Rate Review is available to provide technical assistance to any FQHCs interested in transitioning to the APM.

Regarding change of scope adjustments, the regulations are clear that an FQHC must request a change in scope from DOH. APCA has suggested that the timelines outlined in 7 AAC 145.700 and 7 AAC 140.200 conflict, specifically:

1. The requirement to notify DOH within 45 days after a change of scope occurs (7 AAC 145.700).
2. The requirement to provide additional reports substantiating the change on or before:
    a. The last day of the fifth month after the close of the health clinic's fiscal year in which the change occurred, **and**
    b. The last day of the fifth month after 12 continuous months of operation with the change (7 AAC 140.200).

These provisions do not conflict—they are complementary. The first requirement ensures timely notification of a change, while the second ensures sufficient time to provide supporting documentation for rate evaluation. If APCA is aware of other FQHCs who are interested in the transition but have not notified DOH, we would encourage those facilities to notify DOH so that we can begin the process as soon as possible.

Outstanding Issues for State Plan and Regulatory Revision.

DOH acknowledges APCA's prior requests for revisions to cost reporting requirements and written guidance for compliance. However, we seek clarification on which specific issues

APCA believes remain unaddressed. DOH has already implemented regulatory changes to remove productivity standards from FQHC rate-setting, as previously requested by APCA.

Additionally, DOH does not have a record of receiving a July 2023 letter from APCA. However, we are aware of a May 2023 letter. Could APCA confirm whether this is the correspondence being referenced? If so, we request that APCA provide updated correspondence outlining any remaining items it wishes DOH to consider that have not yet been addressed. We may be able to incorporate these concerns into our ongoing rate study in collaboration with Guidehouse, ensuring they are appropriately evaluated as part of the review process.

Alaska Medicaid Rate Study

Guidehouse's Role

DOH has contracted with Guidehouse to conduct a comprehensive study of rate methodologies across the Alaska Medicaid program. Specifically in relation to FQHCs, Guidehouse is focusing on two primary areas: (1) to provide additional capacity to DOH to analyze the concerns raised by APCA, including any financial implications and (2) to leverage national expertise to assist DOH in evaluating the APM.

Importantly, their role is not to revisit or redo the work already completed, but to build upon and advance the progress DOH and APCA have already made together. To that end, Guidehouse has been fully briefed on the discussions and work undertaken with APCA to ensure continuity. Additionally, DOH recognizes that many FQHCs have already provided substantial data through standard cost reporting processes. Guidehouse will prioritize using existing data whenever possible, and any additional data requests will be carefully designed to be complementary and supplementary rather than duplicative.

Data Sharing

At the request of APCA, DOH has explored opportunities to reduce administrative burden on FQHCs by leveraging existing data already on file to fulfill certain information requests for the rate study. DOH supports this approach and has identified the specific information in its possession that can be shared with Guidehouse the purposes of this study.

Following the FQHC Rate Study Kickoff Meeting, the Department determined that a data-sharing agreement is not required for this data transfer to Guidehouse. Per page 8 of 17 in the FQHC Kickoff presentation, the following data has been or will be requested from providers for the rate study:

- Signed copies of the provider's two (2) most recent CMS 224-14 Medicare Cost Reports (MCRs)
- Financial statements (audited preferred) corresponding with the CMS 224-14 cost reporting periods
- Supplemental data survey capturing information not included in the CMS form, including:
- Costs not detailed on the CMS form
- Programs and services provided by the organization
- Number of encounters by payer and provider type
- Supporting documentation for any Change of Scope requests

Upon review of the ORR records, the Department has confirmed that the most recent Medicare Cost Reports (MCRs) and audited financial statements (AFS) are available for the following FQHCs:

- Bethel Family Clinic
- Dahl Memorial Clinic
- Kodiak Community Health Center
- Mat-Su Health Services
- Seward Community Health Center

These records will be shared with Guidehouse immediately for use in the rate study. All additional required information must be provided directly by the FQHCs per request.

Additional Considerations

DOH appreciates APCA's continued engagement and feedback on the implementation of policies related to new start rate-setting, scope change rate adjustments, and the PPS-to-APM transition. We recognize the importance of timely implementation and share APCA's goal of ensuring that FQHCs receive appropriate rate adjustments as efficiently as possible. DOH must ensure compliance with federal and state requirements, including the proper regulatory and State Plan amendment processes. Any changes moving forward must be implemented in a manner that aligns with federal Medicaid law and ensures CMS approval. This approach is critical to securing long-term stability and preventing compliance risks for both DOH and FQHCs.

Sincerely,

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