Alaska Primary Care ASSOCIATION

August 11, 2023

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Commissioner
Alaska Department of Health (DOH)
3601 C Street, Suite 902
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By Email: Heidi.hedberg@alaska.gov

Re: Medicaid Reimbursement of Federally Qualified Health Centers (FQHCs) in Compliance with Legal Requirements Established under Federal Law

Dear Ms. Hedberg:

The Alaska Primary Care Association (APCA) appreciates the openness DOH officials have expressed to work with APCA on resolving concerns about the Medicaid payment issues. In this spirit, I am writing to you to share an overview of what APCA has determined to be the key areas where Medicaid FQHC payment in Alaska does not conform with requirements under federal law. We have engaged legal counsel to analyze these issues on our behalf.

With respect to each issue, we can supply more detailed analysis and research, should your team wish. This letter is intended as an overview of the issues identified, to inform the agenda for an upcoming meeting between DOH and APCA on this topic.

I. Summary

APCA's member FQHCs have noted in recent years a discrepancy between their encounter payment rates under the Medicaid FQHC prospective payment system (PPS) or alternative payment methodology (APM), and their allowable costs per visit, with the payment rate failing to meet the centers' costs. The federal law concerning Medicaid FQHC payment is intended to provide for cost-related payment.

The analysis that APCA undertook in conjunction with legal counsel revealed that Alaska DOH's payment policies for FQHCs diverge from federal requirements in several ways, which have likely contributed to the growing disconnect between payment rates and the centers' cost structures.

As described in Section III below, the flaws revealed in our analysis included the following:

- **Defective PPS Rates.** The methodology used by DOH to calculate initial rates for Fiscal Year ("FY") 2001 unlawfully applied provider productivity standards, suppressing PPS rates downward, and today, fails to cover the full scope of FQHC services available under the Medicaid benefit.
- **Erroneous PPS Rates for "New Start" FQHCs.** PPS rates for FQHCs established after FY 2000 (i.e., "new starts") are based on statewide averages, inconsistent with federal statutory requirements and the requirements in Alaska's State plan.
- **Improper Application of Inflationary Adjuster.** For three years (2016-2018), the application of the Medicare Economic Index to PPS rates was canceled, in conflict with federal requirements.

- **Inadequate Rate Adjustments for Changes in Scope**. Alaska appears not to have a clear or well-functioning process for offering FQHCs the opportunity to seek rate adjustments due to changes in an FQHC's scope of services.
- **Definitions of Covered Benefit and "Visit**." For purposes of rate-setting, DOH relies extensively on Medicare definitions of covered FQHC services, and of FQHC billable "visits." Due to significant differences between the Medicare and Medicaid covered benefits, this is unreasonable. Cost reporting materials specific to the Medicaid scope of FQHC services should be used for rate-setting.
- **Administration of APM.** The APM is not administered precisely as described in the State plan, and the periodic rebase under the APM, in particular, is not conducted using transparent standards or reliable timelines.
- **Other Payment Issues.** Our analysis also revealed various other concerns regarding Medicaid FQHC payment. The most significant among these is that secondary payment to FQHCs for services furnished to full-benefit dual eligible beneficiaries (FBDEs) is not sufficient to meet federal requirements.

A consistent theme noted in our analysis of the issues is that generally, the FQHC payment requirements in Alaska's federally-approved State plan are consistent with federal law; the noncompliance relates primarily to State regulations and informal practices. Another consistent theme noted in the analysis that we undertook is that because of the longstanding nature of the various noncompliant rate-setting and rate adjustment practices in Alaska (the FQHC PPS was implemented 22 years ago), "correcting" the PPS or APM rates through reverse engineering is essentially impossible. In Section IV below, we set forth several potential pathways for DOH/APCA discussions focused on addressing the issues identified here.

II. Statutory Background and Framework

A. Section 330 of the Public Health Service Act

As background, we note that the majority of APCA's members are recipients of federal grants under Section 330 of the Public Health Service ("PHS") Act, 42 U.S.C. § 254b ("Section 330"). In order to receive Section 330 grant funds, a community health center must (among other requirements): (1) be located in a medically underserved area or be serving a medically underserved population; (2) be community-based—a majority of its Board of Directors must be patients of the center; (3) provide a comprehensive range of primary and other health services; (4) provide health care services to Medicaid recipients; (5) make "every reasonable effort to collect appropriate reimbursement for its costs in providing health services to [Medicaid recipients]"; and (6) serve all residents of its community, regardless of any patient's ability to pay.[1]

The purpose of the Section 330 grant is to pay the cost of providing comprehensive health center services to the uninsured and underinsured, "regardless of ability to pay." Section 330 funds *are not to be used to support the care provided to Medicaid recipients*, as that care is expected to be paid for by Medicaid funds. Federal law governing Medicaid payment to FQHCs was expressly drafted to ensure that Section 330 funds do not, directly or indirectly, subsidize state Medicaid programs' payments.[2]

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[1] 42 U.S.C. §§ 254b(a)(1), 254b(j)(3)(A), 254b(j)(3)(E), 254b(k)(3)(F), 254b(j)(3)(G)(i), 254b(j)(3)(H)(i).

[2] *See Three Lower Counties v. Maryland*, 498 F.3d, 294, 297-98 (4th Cir. 2007) (citing H.R. Rep. No. 101-247, at 392-93, reprinted in 1989 U.S.C.C.A.N. 2118-19).

B. FQHCs in Medicaid

The Medicaid statute defines the term "Federally-qualified health center" as including a Section 330 health center grantee or subrecipient; an FQHC "look-alike" (an entity designated by HRSA as meeting Section 330 program requirements, which does not receive a Section 330 operating grant); or an outpatient health facility operated by a tribal organization or urban Indian organization.[3]

The FQHC designation results in two main consequences for entities. First, each state participating in Medicaid must include specified services as covered in its state plan.[4] Such services—known as "mandatory" services—include those provided by "Federally-qualified health centers."

Second, FQHCs are required to be paid for the range of services included in the covered benefit under the cost-related PPS methodology described in Section 1902(bb) of the SSA. In 1989, Congress enacted the requirement for a state to pay an FQHC one hundred percent of its reasonable costs in furnishing its "[FQHC] services" and "any other ambulatory services" included in the State plan that the center provides.[5] Subsequently, the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 ("BIPA") amended federal law to establish a Medicaid FQHC PPS to pay for a comprehensive range of services furnished by FQHCs.[6]

Each section below describes these applicable legal requirements in detail and then explains how Alaska's Medicaid payment to FQHCs is inconsistent with the requirements.

III. Analysis of Payment Issues

A. Original PPS Rates (for FQHCs Recognized in or Prior to Fiscal Year 2000)

The Medicaid FQHC PPS, described in Section 1902(bb) of the SSA, is a bundled, prospective, cost-related payment methodology resulting in a fixed, per-visit rate. The original PPS rates, effective for services rendered on or after January 1, 2001, were required to be based on an average of 100 percent of the FQHC's reasonable cost of providing Medicaid covered services in a base period (Fiscal Years (FY) 1999 and 2000). The PPS rate is equal to a formula, as follows:

[allowable costs of furnishing the FQHC benefit in the base period (numerator),

divided by

total FQHC qualifying visits in the base period (denominator)]

Each FQHC's unique per-visit rate must account for the costs of furnishing an FQHC benefit comprised of two parts: "federally-qualified health center (FQHC) services" and "any other ambulatory service" offered by the FQHC and otherwise included under the State plan.[7] The PPS rate must include the costs that are "reasonable and related to the costs of furnishing" the services included in this benefit. SSA § 1902(bb)(2). Some State Medicaid agencies used cost limitation devices, including provider productivity standards, upper payment limits, and administrative cost caps, as part of the process for setting the initial 2001 PPS rates. As described more below, federal

[3] SSA § 1905(*l*)(2).
[4] SSA 1902(a)(10)(A) (42 U.S.C. § 1396a(a)(10)(A)) (cross-referencing § 1396d(a)(1)-(5), (17), (21) & (28)).
[5] Omnibus Budget Reconciliation Act ("OBRA") of 1989, Pub. L. No. 101-239.
[6] The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554, codified at 42 U.S.C. §§ 1396a(bb)(1) – (6).
[7] SSA § 1905(a)(2)(C).

courts have held that these cost-limiting policies, particularly if they did not permit individual consideration of the reasonableness of specific cost items, violate federal law.[8]

Alaska's Medicaid State plan[9] provides that the 2001 FQHC PPS rates were to be set using reasonable cost data from the FQHC's 1999 and 2000 cost reports. The provisions on the setting of the original PPS rates are consistent with the federal requirements described above. However, DOH implemented various limitations in setting FQHCs' original rates that were inconsistent with federal requirements and were not authorized in the State plan.

Specifically, Alaska used productivity standards in determining how many "visits" occurred, for purposes of the *denominator* in the PPS rate formula. For purposes of FQHC cost reporting for the base years (FYs 1999 and 2000), DOH imposed a provider productivity standard in setting PPS rates—i.e., an expectation that physicians and midlevel clinicians respectively furnish a specified minimum number of visits per year.[10] Under a productivity standard, to the extent that the number of actual reported visits per full-time equivalent for each group of clinicians falls short of the expectation, the minimum visit count is substituted for the actual count. The use of the provider productivity standard is not mentioned in Alaska's Medicaid State plan provisions on FQHC PPS rate-setting.

The use of the productivity standard is legally unsound for purposes of the Medicaid FQHC PPS. In *Community Health Center v. Wilson-Coker,* the U.S. Court of Appeals for the Second Circuit ordered the district court to determine whether the provider productivity standard, which in Connecticut's case, was expressly included in the Medicaid State plan, was reasonable.[11] The district court then held that the Centers for Medicare & Medicaid Services' (CMS') reasoning in adopting the then-applicable provider productivity standard for purposes of the Medicare FQHC cost reimbursement (in regulations that CMS promulgated in 1996) was not entitled to deference, in part because CMS had borrowed the standard in question from a policy used, but subsequently discredited, by HRSA for purposes of the community health center grant program. In addition, the court noted that CMS and Connecticut had not evaluated whether in Connecticut, the productivity standard would result in rates that captured all costs "reasonable and related" to furnishing the full Medicaid FQHC benefit.[12] Connecticut subsequently suspended use of the standards.

The *Wilson-Coker* decision demonstrates that the use of provider productivity standards in determining allowable costs for the Medicaid FQHC PPS is generally considered unreasonable. Further, as a policy matter, productivity standards are discredited since, through the adoption of a

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[8] *See Community Health Ctr. v. Wilson-Coker,* 311 F.3d 132, 140 (2d Cir. 2002); *Chase Brexton Health Servs. v. Dep't of Health and Mental Hygiene,* 411 F.3d 457 (4th Cir. 2005); *Three Lower Counties Community Servs. v. State of Maryland,* 498 F.3d 294 (4th Cir. 2007).

[9] Alaska Medicaid State plan, Att. #4.19-B, p. 2a (Methods and Standards for Establishing Payment Rates: Federally Qualified Health Center Services)

[10] Alaska regulations clearly set forth the use of a productivity standard in FQHCs (3,050 annual visits for physicians; 2,100 annual visits for "midlevel practitioners") only for purposes of the APM. 7 AAC 145.710(b). As to the setting of the original base year rates under the PPS, the State regulations provide: "Reasonable costs must be determined by using the same methodology used under [Section 1833(a)(3) of the SSA]," which in turn refers to Medicare's former reasonable cost reimbursement system for FQHCs. 7 AAC 145.700(a). That system used a productivity standard (an expectation of 4,200 visits per year for physicians and 2,100 for other clinicians).

[11] 311 F.3d at 139-140.

[12] *Id.* at *7-*8.

Medicare PPS methodology, effective in Fiscal Year 2015, the Medicare program itself has rejected the use of productivity standards in determining FQHCs' allowable costs per visit.[13], [14]

In addition to the use of the productivity standards in setting the visit count for the PPS rate denominator, restrictions on the determination of reasonable costs under the original Medicaid FQHC PPS rates (i.e., those costs informing the *numerator* in the PPS formula) were identified in our review. Alaska's cost reporting standards appear to be based overwhelmingly on Medicare standards, and as described further below, it is not clear whether the original PPS rates were set using cost reporting that fully reflected the provision of the full scope of "other ambulatory services"—a portion of the Medicaid FQHC benefit that does not correspond to the FQHC benefit in the Medicare program. The State regulations incorporate Medicare standards by reference, stating, for example, "health clinic costs [are] allowable costs if they are documented costs as described in 42 C.F.R. 405.2468. . . ."[15] The cited Medicare regulation describes "typical FQHC costs" as including costs associated with the scope of the covered Medicare FQHC benefit, which, as noted above, is different from the covered Medicaid benefit.[16]

Additionally, the State regulation on FQHC services and payment conditions refers to various limitations on allowable costs, such as costs being unallowable if they are related to "services and supplies furnished to non-Medicaid recipients for free or without regard to the recipient's ability to pay."[17] This reflects CMS' former so-called "free care rule," which CMS rescinded via guidance in 2014.[18] That limitation in the State regulation is obsolete and should be withdrawn.

B. Rate-Setting for "New Start" Health Centers

For entities that first qualify as a FQHC after FY2000 ("new start" FQHCs), the PPS rate is established differently than for other FQHCs. For new start FQHCs, federal law requires States to set the initial rate for the first year that the FQHC qualifies as such based on the rates established for an FQHC in the same or adjacent areas with a similar case load, or "in the absence of such center or clinic, in accordance with the regulations and methodology referred to in paragraph (2) [*i.e.,* the use

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[13] SSA § 1834(o).

[14] Please note that given that we conclude that the use of productivity standards in general is unreasonable, we are not addressing in this letter concerns with specifics of how the productivity standards have been implemented (e.g., how FTEs are measured, and whether the standard is applied at the individual clinician level or applied globally to the number of FTEs represented by all clinicians of the same class, etc.).

[15] 7 AAC 145.700(d).

[16] *Compare* SSA 1861(aa)(3), 1905(a)(2)(C). Some examples of the "other ambulatory services" whose costs would be improperly excluded using such a definition are those associated with physical and occupational therapy and speech language pathology, if covered under the State plan. In addition to the major concern that Medicare's FQHC bundle does not include the "other ambulatory services" included in the Medicaid bundle, there are numerous other ways in which the Medicare program structures FQHC cost reports differently from State Medicaid programs. For example, under current Medicare legislation, FQHC "telehealth" services are considered a "non-FQHC" service, with telehealth costs to be segregated from "FQHC services" costs (see SSA 1834(m)(8)); whereas most Medicaid programs, including Alaska's, consider telehealth services furnished by FQHCs to fall within the FQHC benefit. Similarly, the Medicare program requires care management costs to be separated from FQHC service costs on the cost report (see 42 C.F.R. § 405.2464(c)), whereas most Medicaid programs do not require this, and consider care management to be a component of the FQHC service.

[17] 7 AAC 145.215

[18] CMS, SMD# 14-006, Re: Medicaid Payment for Services Provided without Charge (Free Care) (Dec. 15, 2014).

of the FQHC's own costs in a base period] or based on such other tests of reasonableness as the Secretary may specify."[19] As with other FQHCs, new start FQHCs' PPS rates, once established, must subsequently be adjusted annually for MEI and must be adjusted to reflect changes in the scope of services.

Alaska's rate-setting process for new starts is described in the State plan by echoing the requirements in the federal statute.[20] However, the State regulations on establishment of PPS rates are inconsistent with the federal law, providing, for FQHCs enrolling during or after FY2000, that (1) if the FQHC submits cost data for a minimum of six months during the FY1999-FY2000 period, the FQHC may request payment at a per-visit rate based on cost data; and (2) otherwise, the FQHC will be paid a per-visit rate "equal to the statewide weighted average of the total Medicaid per-visit payment rates made to health clinics. . . ."[21]

FQHCs established after FY2000 thus have had no choice but to be assigned a rate reflective of the statewide average, rather than their own cost-related rate. It appears that no effort is made by DOH to identify centers in a nearby area with a similar caseload, and further, no subsequent adjustment is made to account for the new start's actual cost structure.

The use of statewide averages in setting new starts' rates is inconsistent with the federal law described above. As CMS (then the Health Care Financing Administration) explained in a September 2001 guidance relating to implementation of the Medicaid FQHC PPS:

> *The key issue is similarity of caseload.* If there are no FQHCs/RHCs in the same or adjacent area with a similar caseload, the state may then calculate the rate for the new FQHC/RHC based on projected costs after applying tests of reasonableness . . . .[22]

Alaska FQHCs' new start rates from FY2001 onward are not even approximately tailored to the specific characteristics or case load of the individual FQHC, as required by the CMS guidance.

C. Adjustment of PPS Rates for Inflation

For FY2002 and later fiscal years, State Medicaid agencies are required to pay FQHCs at a rate equal to the previous year's PPS rate, adjusted by an inflationary index—the Medicare Economic Index (MEI) applicable to primary care services.[23] The federal law is clear that the MEI must be applied annually, without exceptions.

Alaska nonetheless amended its State plan to provide, "For state fiscal year 2016, 2017, and 2018, after the initial year for a center, the center will be paid the amount (on a per visit basis)

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[19] SSA § 1902(bb)(4).

[20] Alaska Medicaid State Plan, Att. 4.19-B, pages 2a, 2b. A second passage, located after the description of the APM methodology, describes a different "new start" rate-setting process. From context and location of the sentence in the provision, it appears that DOH intended for this second methodology to apply only to FQHCs whose initial rates are established as APM rates. The second passage states: "Initial payments for FQHCs becoming qualified after State FY00 are established by computing a statewide weighted average payment to other centers or by cost reporting methods if a minimum of six months of cost data for years 1999 and 2000 is submitted."

[21] 7 AAC 145.700(g).

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

[23] SSA § 1902(bb)(3)(A).

equal to the amount paid in the previous center fiscal year with no increase by the percentage increase in the [MEI]."[24]

Withholding the application of the MEI for any fiscal year, for purposes of the FQHC PPS, violates the requirement in the law that this inflationary factor be applied annually. Our legal counsel could not identify any federal authority that would condone cancellation of the annual MEI adjustment under the PPS.

D. Adjustment of PPS Rates to Reflect Changes in the Scope of Services

The federal law requires that beginning in FY 2002, each health center's PPS rate be adjusted "to take into account any increase or decrease in the scope of such services furnished by the center or clinic during [the prior] fiscal year."[25]

Areas of noncompliance identified in our review include first, the State's definition of a "change in the scope of services" (the qualifying condition that permits a health center to seek a rate adjustment); and second, the timelines and procedures (or lack thereof) for health centers to apply for and obtain change-in-scope PPS rate adjustments.

As to the definition of a "change in the scope of services," the Alaska State plan does not contain any detail, stating only that after fiscal year 2000, each FQHC's PPS rate must be "adjusted to take into account any increase (or decrease) in the scope of services furnished by the center."[26]

Detail on scope change definitions and processes is thus left to the State regulations. The regulations contain two inconsistent provisions defining qualifying scope changes. One provision states that only a "new or terminated program or service" qualifies as a change in the scope of services, whereas another provision in the same regulation states that an increase or decrease in the "intensity" of a service also qualifies.[27] The definitions in the regulations are unlawfully narrow. CMS guidance requires that the concept of a scope change encompass changes in the "*type, intensity, duration and/or amount of services*."[28] The key feature of the definition is that it allows a rate adjustment for any significant change in the FQHC's manner of delivering the covered FQHC benefit, which also corresponds to a change in the costs of delivering care.[29] Notably, a federal court recently invalidated the State of Florida's definition of an FQHC "change in the scope of services," which was limited to the addition or elimination of a service. The court held that on the face of the federal law, the term "any increase or decrease in the scope of such services" must be broader in

[24] Alaska Medicaid State Plan, Att. 4.19-B, page 2a.
[25] SSA § 1902(bb)(3)(B).
[26] Alaska Medicaid State Plan, Att. 4.19-B, page 2a.
[27] 7 AAC 145.700(f), (k)
[28] Memorandum from Richard Chambers, Acting Director, Family & Children's Health Programs Group, HCFA, to HCFA Associate Regional Administrators (Sept. 12, 2001) (emphasis added).
[29] Importantly, such a change need not be limited to the addition or removal of a discrete service. An increase in the "intensity" of services would occur, for example, if a health center implemented a patient-centered medical home model that resulted in an increase in care management / care coordination services associated with each visit; or if the health center changed its provider mix by employing new specialist physicians (e.g., cardiologists or psychiatrists). A change in "amount" or "duration" of services would occur, for example, if a health center added a behavioral health consultant to its pediatric primary care team, resulting in longer and more resource-intensive well child visits.

meaning than the State's regulation allowed.[30] The court concluded that it did not need to resort to interpreting or deferring to CMS guidance in order to reach that conclusion.

As to timelines and procedures for rate adjustments, perhaps the most critical point here is that *it appears that the State does not provide any meaningfully available mechanism for FQHCs to apply for or obtain a change-in-scope rate adjustment.* This is a major failing since the scope change rate adjustment mechanism is what makes the PPS a "living" payment methodology – one that reflects the full scope of services and clinical practices in the FQHC in a given year. When one considers the dramatic advances in the provision of primary care and behavioral health services by health centers since the implementation of the PPS twenty-two years ago, it is apparent how necessary such rate adjustments are.

The State regulations also contain inconsistent obligations and timeframes. The cost reporting regulation requires FQHCs to submit cost reports by the last day of the fifth month after the close of its fiscal year, and to note any scope change during the relevant fiscal year in the cost reporting materials. On the other hand, the payment rates regulation requires, for example, that for a post-implementation scope change rate adjustment request, the FQHC submit its notification of the scope change to DOH within 45 days "after the change in scope of services occurred."[31] The processes described in the regulations also do not appear to be supported by guidance or instructions clarifying how health centers can apply for rate adjustments. Further, while the State regulation states that annual cost reports are required of FQHCs, it is unclear to what extent DOH enforces or supports routine FQHC cost reporting activities. The regulations also do not explain how the new FQHC PPS rate resulting from a scope change rate adjustment would be computed.

The lack of detail regarding procedures and cost reporting requirements associated with scope change rate adjustments is all the more concerning because Alaska has in place a threshold of 2.5 percent for these adjustments—i.e., in order for the FQHC to qualify for a rate adjustment, "the change in scope of services must have increased or decreased the health clinic's cost per visit by more than two and one-half percent."[32] Unless a State issues detailed cost reporting guidance explaining how the incremental cost impact of a single scope change event is to be measured, such percentage thresholds can result in the exclusion of valid scope change events that have meaningfully impacted a center's cost structure.

Overall, both the narrowness of Alaska's "change in the scope of services" definition and the vague and contradictory procedures described in its regulations, amount to a situation where FQHCs do not have viable access to rate adjustments that are required under the law.

E. Scope of the Covered FQHC Benefit

"Federally-qualified health center (FQHC) services" are defined in the federal law 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 health centers in areas with a shortage of home health agencies.[33] FQHC services also include services "incident to" the

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[30] *Family Health Ctrs. of Southwest Florida,* 2023 WL 2264138 (M.D. Fla. Feb. 28, 2023).

[31] 7 AAC 140.200(f); 7 AAC 145.700(f)(2)(A).

[32] 7 AAC 145.700.

[33] SSA §§ 1905(a)(2)(C), 1905(*l*)(2)(A).Please note that additionally, effective for services rendered on or after January 1, 2024, the services of mental health counselors (MHCs) and marriage and family therapists (MFTs) will be added to the core Medicaid FQHC benefit. *See* Consolidated Appropriations Act 2023, Pub. L. No. 117-328, Section 4121(b)(1) (amending Section 1861(aa)(1)(B) of the Social Security Act to include the services of MHCs

services of the above-listed clinicians. These services are sometimes referred to collectively as the "core" FQHC services. Importantly, in addition to the "core" FQHC services, States must also cover through the FQHC benefit any "other ambulatory services" included under the State plan, which the FQHC has elected to offer.[34],[35]

The terms in the State plan describing covered "core" FQHC services are consistent with the federal law described above. However, the State has introduced inappropriate restrictions through the State regulations. As one example, while we are pleased the DOH has recently amended the Medicaid regulations to add the services of professional counselors and marital and family therapists to the Alaska Medicaid FQHC benefit, the revised regulation does not classify these services (or for that matter, the services of clinical social workers and clinical psychologists working in the FQHC) as "core" Medicaid services.[36] Making this clarification is necessary to ensure that services of these core behavioral health clinicians are included within the FQHC benefit regardless whether the State independently covers these clinicians' services under the State plan.

Further, the core Medicaid FQHC benefit is required under federal law to encompass not only services furnished by FQHC core practitioners, but also, services "incident to" those services.[37] "Incident to" items and services range from equipment used in the course of providing care, to laboratory and x-ray services, to the services of clinical personnel in conducting intake, venipuncture, or other similar services. The State regulations, on the contrary, state that Medicaid will not pay under the PPS for services "that the department determines to be incidental to primary care services."[38]

The State regulations also introduce unlawful limitations on coverage of and payment for "other ambulatory" services. The State plan provides that both core and "other ambulatory services" are covered in the FQHC benefit without any limitations,[39] but the State regulations enumerate 13 specific "ambulatory services." Such a list is bound to become obsolete at any point when a new State plan outpatient service is added to the Medicaid benefit (and may not at present encompass any outpatient service covered under the State plan). The regulation should not include a limited list of covered "other ambulatory services," but instead, should simply echo the requirement in the federal law that the FQHC benefit encompass any outpatient service covered under the State plan and offered by the FQHC.

Please note that since any expansion in the scope of services covered through the PPS methodology amounts to a change in the "type" of services covered under the FQHC benefit, FQHCs

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and MFTs in the core rural health clinic benefit; this provision is incorporated within nested statutory provisions to result in addition of MHCs (or licensed professional counselors) and MFTs to the Medicare and Medicaid FQHC benefit packages).

[34] SSA § 1905(a)(2)(C).

[35] The concept of "other ambulatory services" was amplified in a CMS informal guidance issued in 2001. *See* Memorandum from Richard Chambers, Acting Director, Family & Children's Health Programs Group, HCFA, to HCFA Associate Regional Administrators (Sept. 12, 2001) #8 (the FQHC benefit must include, in addition to the core services, "*all* Medicaid covered services allowed under 1905(a)(2)(B) and (C) of the Social Security Act . . . which includes ambulatory services.").

[36] See 7 AAC § 140.215(e).

[37] See SSA § 1905(l)(2)(A) (incorporating by reference SSA § 1861(aa)(1)).

[38] 7 AAC 140.215(b).

[39] Alaska Medicaid State plan, Att. 3.1-A, p.1.

should have an opportunity to seek a rate adjustment any time a new ambulatory service is recognized.

F. Definition of Billable "Visits"

Federal law requires States to calculate the FQHC PPS rate "on a per visit basis."[40] The term "visit" is not defined in the federal law relating to payment of FQHCs under Medicaid. States have significant discretion in defining billable FQHC visits. Our analysis identified two significant flaws in Alaska's regulatory definition of a billable FQHC "visit": first, the definition is vague; and second, the definition of a "visit" as a billable event does not appear to be consistent with the definition of a "visit" used for FQHC rate-setting.

The Alaska FQHC payment regulations define a "visit" as "the aggregate of face-to-face encounters, occurring on the same calendar day and at a single location, between the health clinic recipient and one or more rural health clinic [or federally qualified health center] professionals," with two exceptions allowing for more than one billable visit on the same day.[41] The regulation does not specify which clinicians qualify as a "professional" who is qualified to provide a billable visit. The "visit" definition also appears to exclude the telehealth modality, even though recent State legislation required the coverage of telehealth services in FQHCs.

The inconsistency between the "visit" definition used by DOH for purposes of Medicaid billing, and for purposes of rate-setting, is also of concern. Under a PPS methodology, the "visit" as a unit of service functions as both the billable Medicaid event and the unit for apportioning allowable costs on the cost report. The regulation addressing the counting of "visits" for purposes of cost reporting (7 AAC 145.710) should employ a "visit" definition that is the same as the definition Medicaid uses to determine which "visits" are a billable event (7 AAC 145.739). Recent DOH proposed rules would measure an FQHC's annual number visits, for purposes of the cost reporting yielding rebased rates under the APM, by the FQHC's number of visits for the year under *Medicare* standards. This is inappropriate, since both the scope of the Medicare FQHC covered benefit and the Medicare "visit" definition differ from their counterparts under the Alaska Medicaid program.

G. Alternative Payment Methodology (APM)

Federal law allows States to use an alternative payment methodology (APM) in lieu of meeting the requirements of the PPS methodology set forth above, to pay for services included in the FQHC benefit.[42] In order to use an APM, States must meet three conditions. First, before a State may enforce an APM on a specific health center, that FQHC must have agreed to it. Second, the APM must result in payments that are at least equal to the amount that the FQHC would have otherwise been paid under the PPS approach. Third, any APM must be described in the State plan.

Alaska has included an APM in its State plan and regulations. The APM features various major differences from the PPS methodology, including the use of a different (more generous) inflationary adjuster than the MEI, and a provision for a "rebase" (i.e., a re-setting of the per-visit rate using more recent cost data) at least once per four years. Nonetheless, many of the features of PPS payment are also used under Alaska's APM, such as the per-visit payment framework, the

[40] SSA § 1902(bb)(2).
[41] 7 AAC 145.739(3).
[42] SSA § 1902 (bb)(6).

provision for annual inflationary adjustments and adjustments as appropriate to reflect the impact of scope changes, and the setting of rates based on FQHCs' reasonable costs.[43]

As to the first federal requirement for APMs – that the APMs must be described in the State plan, and the State must carry out the methodology consistent with that description – there is a considerable gap between the methodology as described in the State plan, and as implemented. As one example, the State currently uses provider productivity standards in setting centers' rebased rates, although State plan merely provides that payment under the APM (as with the PPS) is based on "the allowable and reasonable costs of services furnished." For the same reasons described above with respect to payment under the PPS, the use of the productivity standard is also unreasonable under the APM.

Further, the issues identified in Sections III.E and F above concerning the scope of the covered FQHC benefit and the billable visit definition call into question the integrity of the rebasing processes under the APM. Because Medicare covers a different FQHC service array than Medicaid, and also employs a different "visit" definition than Alaska Medicaid, the use of Medicare cost reports for purposes of the rebasing under the APM is inappropriate unless the State provides a detailed template and instructions explaining how Medicare cost reports will be supplemented or adjusted (with respect to both allowable cost centers and qualifying "visits") to reflect the differing Medicaid requirements. We do not believe DOH provides a clear *Medicaid* template or instructions for centers undergoing a rebase.

Additionally, the State plan provides that under the APM (as under the PPS), FQHCs will have an opportunity to seek scope change rate adjustments. As described above, it does not appear Alaska has made that opportunity meaningfully available to health centers paid under either methodology.

Finally, the State plan provides that rebasing will occur "at least every four years." The State regulations elaborate on the schedule for rebasing, with rebased rates to take effect in the year beginning less than 12 months after the close of the second cost reporting year whose data are used in the rebasing.[44] It is our understanding that in practice, the review and auditing of cost report data for the two prior fiscal years for purposes of the rebase is often an extremely protracted process, and the FQHC may not receive retrospective payment adjustments back to the date the rebase was scheduled to take effect. The State should ensure that once the rebased rates have been set, the rates are applied according to schedule.

We also identified concerns surrounding the second requirement in federal law—that that the APM be applied only to those FQHCs that agree to it. While the State regulations provide that DOH and the clinic may "make an agreement" to enter the APM,[45] we have not seen any indication that DOH memorializes APM participation in a contract or other agreement.

Last, and perhaps most importantly, federal law and implementing guidance require that States conduct a reconciliation annually to ensure that payment under the APM is at least equal to payment under the PPS. The regulations echo this requirement, and state that "if the payment rate [under the APM] is less than [the amount under the PPS], the department will pay the health clinic [under the PPS]."[46] However, in order to conduct that procedure properly, a State must update PPS

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[43] Alaska Medicaid State plan, Att. #4.19-B, p. 2b Methods and Standards for Establishing Payment Rates: Federally Qualified Health Center Services)

[44] 7 AAC 145.720(b).

[45] Alaska Medicaid State plan, Att. #4.19-B, p. 2b; 7 AAC 145.700(c).

[46] 7 AAC 145.700(c)(3).

rates according to federal requirements, including setting an accurate cost-related rate at the inception of the entity's FQHC status, applying the MEI annually, and adjusting the PPS rates to reflect changes in the scope of services—*even for those centers that have elected to be paid under the APM*. In practice, as described above, DOH does not appear to be following these procedures.

The APM provisions in the State regulations contain a limitation that is inconsistent with the law, providing that DOH "will annually evaluate the payment rate [under the APM] to ensure it is within the payment limit set under 42 C.F.R. 447-300-447.371."[47] This citation refers to the upper payment limits (UPLs) in the federal regulations, which are established collectively for certain categories of Medicaid services. While the Medicaid UPLs apply to outpatient "clinics" referred to in the federal Medicaid regulations, they do not encompass services furnished by FQHCs.

H. Payment for Services Rendered to Dual Eligible Beneficiaries

Most Alaska FQHCs have Medicaid encounter rates that are higher than the payment amounts they receive under Medicare's FQHC PPS. This is not unusual, since the Medicare PPS rate is based on national average costs, with various adjustments, rather than on each specific center's allowable costs per visit, as the Medicaid FQHC PPS is. Nonetheless, when FQHCs file secondary claims with Alaska Medicaid for services rendered to FBDEs that are covered under both Medicare and Medicaid, Medicaid makes secondary payments equal only to the Medicare coinsurance amount, rather than the (greater) difference between Medicare's payment and the full Medicaid encounter amount.

This practice is inconsistent with federal Medicaid law on third-party liability (TPL). Where a provider's Medicaid rate is higher than the Medicare allowed amount, the federal Medicaid regulations require that Medicaid's secondary payment should equal the full amount by which "payment allowed under the agency's payment schedule [here, the Medicaid FQHC PPS or APM] exceeds the amount of the third party's payment."[48] A federal court affirmed this conclusion in the context of FQHC services when it held that a State's practice of making a secondary payment for an FQHC visit equal only to the 20% Medicare coinsurance, rather than the full difference between Medicare's payment to the FQHC and its Medicaid APM rate, was inconsistent with federal law.[49]

IV. Potential Solutions

APCA looks forward to dialogue with DOH concerning means for correcting the noncompliance of the FQHC PPS and APM processes with federal law. Generally we would recommend addressing the issues in three steps.

A. Payment for Services Rendered to Dual Eligible Beneficiaries

The issue addressed in Section III.H above is the most straightforward issue raised in this letter. DOH may resolve this issue by immediately modifying its secondary payment practices to ensure that when an FQHC submits a claim for a service rendered to an FBDE, and the service is covered under both the Medicare and Medicaid programs, DOH makes a secondary payment equal

[47] 7 AAC 145.700(c)(4).

[48] 42 CFR § 433.139(b). Notably, this obligation is not limited by Medicaid State Plan provisions that more narrowly address Medicaid payment of "Medicare cost-sharing" under the State plan for Qualified Medicare Beneficiaries who are not entitled to full Medicaid benefits.

[49] *Genesis Health Care v. Soura,* 165 F. Supp. 3d 443 (D. S.C. 2015).

to the full difference between Medicare's payment (typically 80% of the Medicare allowed amount) and the full Medicaid payment amount. This change in policy would bring DOH into compliance with federal law, and rectify a situation where FQHCs are effectively being penalized for providing services to patients who are FBDEs.

B. Addressing Rate-Setting and Rate Adjustment Issues Under the PPS

As an additional area of discussion between APCA and DOH, we request to focus on the issues identified in Sections III.A-F above. These portions of the letter describe areas where DOH FQHC PPS rate-setting and rate adjustment procedures do not track with federal requirements. Cumulatively, over the course of the years since the FQHC PPS has been in effect, the result of this noncompliance has been FQHC PPS rates that fail to keep pace with FQHCs' reasonable costs of providing the covered benefit.

We request that DOH revise its regulations prospectively to achieve compliance with the federal requirements in the areas identified above, and additionally, that DOH implement a transparent and accessible policy for FQHC change-in-scope rate adjustments. Centers should have an opportunity to appeal a denied rate adjustment request.

As to corrective action with respect to FQHC PPS rates that have been cumulatively lowered, over the years, by the use of improper cost containment methodologies, we believe the most tenable approach is for DOH to provide FQHCs with an opportunity to seek a corrected PPS rate, based on a more recent year's cost reports. Such a re-set of the PPS rates could be achieved via a change-in-scope rate adjustment opportunity, with the resulting adjusted rate reflecting the impact of the various qualifying changes in clinical activity for FQHCs over the years since the original PPS rates were set, for which FQHCs have not had a meaningful opportunity to seek an adjustment. Such a rate adjustment will meaningfully restore cost-related rates only if DOH removes improper cost limitations in the regulations and issues clear cost reporting guidance identifying allowable Medicaid FQHC cost centers and qualifying visits. The process would therefore effectively address the inconsistencies with federal law with respect to original and "new start" FQHC PPS rate-setting, as well as both inflation-related and scope change rate adjustments.

Please note, further, that with limited exceptions, the unlawful rate-setting and rate adjustment practices documented in this letter relate to DOH regulations and implementation, not to the language in the federally approved Alaska Medicaid State plan.

The logistical issues associated with the duration of the past rate-setting and rate adjustment noncompliance are the main reason that correction of the PPS rates can be best achieved via a "rebase" rather than by some other type of correction of existing rates. Adjusting for the errors in setting and updating the rates would be at best, challenging, and at worst, impossible, given that it appears DOH established rates for "new starts" using a statewide average, and without collecting any cost report data from the relevant FQHC.

C. Addressing Cost Reporting and Procedural Issues under the APM

We request, additionally, that DOH work with FQHCs that are paid under the APM, to improve the transparency of the cost report requirements, explain the inflationary factor being used to develop the APM, and to ensure that the full scope of Medicaid-covered services and Medicaid qualifying visits is taken into account. Reforms to the APM policies should include clearer timeframes for rebasing, and for the effective date of rebased rates.

APCA appreciates its partnership with DOH in working to ensure that FQHCs in Alaska are able best to fulfill their vital role of providing comprehensive primary care and behavioral health services to Alaska Medicaid beneficiaries. We look forward to discussing with you the proposals in this letter.

Sincerely,

Nancy Merriman
CEO, Alaska Primary Care Association