April 1, 2024

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:

Thank you for your letter of February 15, 2024, outlining the outcome and next steps of the meeting between the Alaska Primary Care Association (APCA) and DOH on January 4, 2024 to discuss Medicaid payment issues for FQHCs. APCA is encouraged by the progress in our discussions. We look forward to our meeting with you [later this month] and to the initiation of work groups on the change-in-scope and "new start" issues.

To help focus these upcoming discussions, APCA is providing several comments below, with the purpose of either identifying federal legal requirements that should guide our conversations, or flagging items we believe should receive higher priority.

Generally, while APCA appreciates that DOH has provided a set of detailed proposals in its February 15 communications, we do not believe that a Frequently Asked Questions (FAQ) document is an acceptable way to resolve areas where the State's current FQHC payment practices conflict with federal law or the Alaska State plan, or where the policies are based on vague or contradictory State regulations. Instead, we encourage DOH to amend the State regulations to clarify these issues.

I. Payment for FQHC Services Rendered to Full-Benefit Dual Eligible (FBDE) Beneficiaries

We view it as a top-priority item for DOH to correct its noncompliance with federal law in making secondary payments for visits that FQHCs furnish to FBDEs. Federal law requires the Medicaid agency to make a secondary payment equal to the full difference between Medicare's payment and the health center's Medicaid cost-related prospective payment system (PPS) or alternative payment methodology (APM) rate, where the Medicaid cost-related payment rate for the FQHC visit exceeds Medicare's allowed amount. Nonetheless, DOH makes a secondary payment equal to only the Medicare coinsurance amount. This is posing ongoing harm to our members, many of which serve a high volume of FBDEs.

This topic was on the agenda at our January 4, 2024 meeting, and was not discussed. We appreciate DOH's offer in your February 15 letter to schedule a separate meeting on this issue, and we request that given its priority level, this meeting be scheduled in advance of our other discussions. We have attached to this letter a recent CMS guidance that clarifies, in the context of the Medicaid

certified community behavioral health clinic (CCBHC) demonstration, the secondary payment obligation described above.

II. Non-Application of PPS Inflationary Adjustment for 2016-2018

APCA appreciates DOH's decision to correct FQHCs' PPS rates, effective July 1, 2024, in order to provide the federally required Medicare Economic Index (MEI) inflationary adjuster to the PPS rates for State Fiscal Years 2016-2018.

APCA would like to request that, when this has been completed, all FQHCs (not just those receiving payment under the PPS) receive notification of their updated PPS rates. As we have noted in our discussions, federal law requires that PPS rates be properly established and updated for all health centers, including those that have elected the APM. All health centers should be apprised of any adjustments (including routine annual adjustments) to their PPS rates.

III. Change-in-Scope Rate Adjustments

APCA appreciates the State's acknowledgment that the State Medicaid regulations relating to FQHC changes in the scope of services need to be reviewed in order to ensure both internal consistency and compliance with federal law. We look forward to participating in the work group on this topic. We wish to provide several initial thoughts below in advance of the discussions.

First, as to procedural issues, we want to urge DOH to clarify the scope change standards and procedures by regulatory amendments. Using an informal guidance, such as the draft FAQ document that DOH shared with us last month, is not sufficient. One key reason for this is that the State regulations are internally inconsistent. As two examples, the timeframes and requirements for reporting changes in scope in 7 AAC 140.200 do not match those in 7 AAC 145.700, and the definitions of "change in the scope of services" referenced within 7 AAC 145.700 are internally inconsistent. Also, it will be more difficult for DOH and health centers to move forward with certainty in implementing and following new or clarified procedures if those procedures are stated only in informal guidance, which may not be consistent with the regulations.

Additionally, APCA urges DOH, as it works toward clarification of its scope change policies, to clarify that DOH does not intend to impose on FQHCs the reporting deadlines described in the current State regulations for scope of services that the FQHCs have experienced in recent years. By DOH's own admission, DOH has not collected or reviewed the annual reports that are described in 7 AAC 140.200(d) as the vehicle for health centers to report scope changes. Additionally, the scope change reporting deadlines in that regulation conflict with the deadlines and procedures described in the other State regulation addressing FQHC scope change (7 AAC 145.700(f)). It would be highly inequitable to foreclose health centers from seeking rate adjustments relating to past scope changes on that ground that the health centers did not follow procedures that are internally inconsistent and, as a practical matter, have been inactive.

As to the substance of requirements for changes in the scope of services, we wish to emphasize, however, that federal law limits the State's discretion on some of the issues listed in your letter, including the following:

Definition of a "change in the scope of services": Per federal guidance, this concept must encompass an increase or decrease in the "type, amount, intensity, or duration" of FQHC services. Defining a scope change as limited to the addition or removal of a discrete service is an unlawfully narrow definition of the concept.

Calculation of a change-in-scope rate adjustment: Consistent with the above, many valid scope change events involve clinical changes more complex than the addition or removal of a discrete service, and accordingly, may impact numerous cost centers. One example would be an increase in the intensity of services due to the implementation of an integrated primary care-behavioral health program. For such changes, an effective rate adjustment cannot be achieved by reference to changes in only one or two isolated cost centers. Similarly, for more complex changes in the scope of services, the impact, if any, of the change on the health center's annual number of visits may not be easily measurable. For this reason, for many valid scope change events, the methodology described in FAQ #33 of the draft FAQ document for calculating the change-in-scope rate adjustment, would be infeasible and/or would not fully account for the cost impacts of the change. Instead, a more comprehensive consideration of the health center cost report would be necessary to give effect to the impact of the scope change.

Determination whether a change in the scope of services occurred: Consistent with the above, if numerical standards such as a threshold percentage change in costs are used to determine whether an event qualifies as a scope change, such thresholds should not be measured using only the percentage change in certain discrete cost centers on the cost report.[1]

Effective date of a change in the scope of services: We read the federal statute, at Section 1902(bb)(3) of the Social Security Act, as requiring that the rate adjustment take effect no later than the beginning of the first year following the year in which the scope change event occurred or began.

How often a change-in-scope rate adjustment is allowed: While it would be reasonable to require health centers to aggregate their rate adjustment requests relating to more than one qualifying scope change event within a single fiscal year, we do not believe that frequency limitations on rate adjustments are otherwise permissible, since the federal legislation at Section 1902(bb)(3)(B) of the Act requires the PPS rates to be adjusted whenever an "increase or decrease in the scope of services" occurs.

Scope change rate adjustments for health centers paid on the APM: A health center on the APM that has experienced a change in the scope of services should be eligible for an adjustment of both its PPS rate (as PPS rates must be maintained/updated for all centers) and its APM rate. The Alaska State plan requires that the APM rates be adjusted to reflect

[1] Further, as to the standard used to determine specifically if a service has been added or removed, it is not appropriate to use as the sole indicator whether there was a change in the checked box on Form 5a, as suggested in your letter. HRSA's service definitions do not align precisely with those used in Medicaid.

changes in the scope of services. While, per the rebase timing stated in 7 AAC 145.720(b), any scope change experienced during the first two years of the four-year rebase cycle would be automatically included in the subsequent rebased rate, DOH should adjust the rebased rate to reflect the impact of scope change events that occur in the third and fourth years of the rebase cycle.

IV. Method for Setting PPS Rates for "New Start" FQHCs

We look forward to work group discussion on this important topic. DOH's practice of permanently establishing rates for FQHCs recognized after 2000 ("new starts") using a statewide average rate conflicts with the specific requirements in the federal statute at Section 1902(bb)(4) of the Social Security Act, and with the Alaska Medicaid State plan. We appreciate DOH's commitment to reevaluating its policies in this area.

As to the list of discussion items related to this topic in DOH's letter, we want to emphasize two points. First, we view it as essential that DOH correct the PPS rates for *current FQHCs whose rate was established using the statewide-average new start methodology*, given that this methodology is noncompliant with federal law and the state plan.

Second, while it will be helpful to discuss potential regional boundaries and case load groupings for purposes of identifying centers "located in the same or adjacent area with a similar case load," per Social Security Act § 1902(bb)(4), these groupings have little impact on a long-term basis if the new start's preliminary rate defined by reference to another center's is replaced, after initial year(s) of operation, by a rate developed based on the new start's own cost structure. The federal statute allows for that methodology, which is commonly used in other states. APCA is advocating for that type of rate-setting methodology, which will allow for meaningfully cost-related PPS rates for all FQHCs. Existing FQHCs whose rates have been established using the statewide average rates should have the opportunity to obtain corrected rates based on their own cost experience.

V. Issues Relating to the Alternative Payment Methodology

We appreciate DOH's commitment to working to clarify the information it provides to FQHCs concerning the reporting requirements, timelines, and other logistics of the APM. Our member health centers appreciate the availability of a rebase APM option under Alaska Medicaid. We believe that once the APM processes are clarified, more FQHCs will elect this option.

We would like to make two general comments to inform our upcoming discussions on this topic. First, with respect to any material addressing the specifics of APM rate-setting and cost report auditing (for example, the explanations in FAQs # 11, 13, 14, and 16), we wish to note that APCA is currently working with FORVIS on an analysis of the cost reporting and rate-setting processes. We look forward to discussing these topics further, but are not in a position at this time to agree with the statements in those FAQ answers.

With respect to the inflationary adjuster, as referenced in item IV of your letter and FAQ #22, we believe this issue warrants further discussion, as there are several irregularities in DOH's adjustment of APM rates for inflation. First, the inflationary adjuster referred to in the State plan (Global Insight's *Health Care Cost Review,* Skilled Nursing Facility Total Market Basket) appears to be

obsolete. It does not correspond to the index that DOH is actually using (referred to variously in DOH's communications as the IHS Markit *Skilled Nursing Facility* Total Market Basket, and as the IHS Markit *Home Health Agency* Market Basket). Second, the IHS Markit index is for practical purposes completely inaccessible to a health center seeking to compare the inflationary adjuster used under the APM with the one used under the PPS. The index is not publicly available, and the use of the midpoints makes its calculation for purposes of any FQHC excessively complex.

The lack of clarity surrounding the APM inflationary factor is a real concern because it means that FQHCs cannot evaluate the payment options under the State plan with full information. Based on DOH's correspondence with member health centers, it appears to us that the adjuster used for purposes of the APM has actually been significantly lower than the Medicare Economic Index (the adjuster used for the PPS) in some recent years. Given the FQHC APM is intended, by statute, to provide for more generous payment than the PPS, this is of concern to APCA and its members.

Since the APM inflationary adjuster referred to in the Medicaid State plan no longer exists, we recommend that the State use, in its place, the Medicare FQHC-specific market basket adjuster, which was first implemented by CMS for purposes of the Medicare FQHC PPS in 2017. The use of this adjuster would provide two key advantages. First, it is publicly available and simple to apply, resulting in transparency that FQHCs would value as they choose between the PPS and APM options. Second, it is based on a market basket specific to FQHCs, and so is presumably more precise than a nursing facility- or home health-based market basket.

APCA's team and members look forward to the specific detailed work group discussions we understand will be scheduled for the upcoming months concerning (1) payment for services rendered to FBDEs, (2) change-in-scope rate adjustments, and (3) rates for "new start" FQHCs. Please see the attached work group plan and state examples compiled for reference.

Sincerely,

Nancy Merriman
CEO