The New Alternative Payment Methodology: **What FQHCs and RHCs Can Expect**

David Fields, CPA, CMA, CFM, June 6, 2024

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Meet the Presenter

David Fields, CPA

Partner

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Agenda

1. Introduction
2. Medicaid and Medicaid Managed Care – What is next?
    1. What does this mean for your health center?
    2. What do you need to do?
3. Refresher
4. Questions and Answers

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Introduction

Why does it matter?

- Single biggest payer for all (or maybe almost all of you)
  - If not by volume then in dollars
- This impacts direct Medicaid AND Medicaid Managed Care
- This has created more certainty and is expected to be the last State Plan Amendment (SPA)…at least for many years
- There are still future cost reports to be filed – like your 2024 NC Medicaid
- Many of the efforts on cash flows – real time wraps are coming…soon
- Why should you care what I have to say about all of this?
- All of the changes discussed for years are now happening, we are in the final stages of implementation!

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Medicaid & Medicaid Managed Care
What is next?

- The new SPA approval/finalization date was this Spring (2024), but was retroactively effective July 1, 2023
- Everyone is PPS, but you all have your own unique PPS rate
  - There will be wrap payments…until real time wrap is effective…hopefully 7/1/24
  - There will NOT be cost settlements for 7/1/23 DOS forward
  - There will still be “some” cost reports during and after the transition
  - There is one PPS rate for all services
- Everyone will be utilizing their 2021 rebased PPS rates + 13% + inflation
- Pharmacy will be paid fee schedule – not in PPS or the cost report

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Medicaid & Medicaid Managed Care
What to do?

- Keep seeing patients, serving your communities and providing great care!
- Help qualifying patients gets enrolled in Medicaid / Managed Care
  - Medicaid expansion execution on your part
- Keep fighting for payment and making sure you work denied claims
  - This does not protect you if the MCO never pays the claim
- Keep track of the Managed Care encounters paid
  - Compare this to your wrap payments and/or your cost report historically
  - When real time wraps – make sure you are paid your PPS rate in total
- Begin budgeting and planning with more certainty
  - Set PPS rate with no settlement

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Medicaid & Medicaid Managed Care
What to do?

- Take your cost reporting process very seriously
  - Remember FQHC Medicare cost report is foundational
  - Your 2022 and your 2023 are cost settled (at least partially)
  - Your 2024 cost report sets your next PPS rate
    - This years is critical and part of your rate setting process
    - If you were not proactive enough now, then already begin thinking about 2027
  - Your 2021 and your 2024 cost reports set your unique PPS rate
    - Based on your cost, dental/medical mix, etc.
    - No 2025 or 2026 NC Medicaid cost reports – still have Medicare
- A new cost reporting template is pending approval, but…

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Medicaid & Medicaid Managed Care
What is next?

- Medicaid Managed Care claims real time…7/1/24
- Direct Medicaid – think NCTracks
  - Cost report settlement, until they can begin paying the PPS rates
- We are still waiting on the mechanism for the state to pay the cost settled Managed Care claims
  - Either for cost settled from 7/1/21 to 6/30/23, or for
  - Emergency SPA PPS from 2/1/22 to 6/30/23
- There continue to be disruptions and transitional challenges, but we are closer
- After the 2024 cost reports are filed and processed, hopefully the state can begin to recover and clear out the backlog

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Medicaid Payment Reform Implementation for FQHCs

Medicaid APM Update

Brendan Riley

VP of Government Relations & External Affairs, NCCHCA

Originally presented on April 12, 2024 NCCHCA Task Force Meeting. Revised as of 4/19/24

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SPA Approved: Quick Recap of APM

- On March 28, CMS approved NC's Medicaid State Plan Amendment to establish a new FQHC Alternative Payment Methodology

- Reminder: This Prospective APM establishes:
  - A new prospective, cost-based encounter rate that is rebased every three years and enhanced by 13% above allowable cost (carving pharmacy out),
  - Real-time managed care wrap payments, and
  - Quarterly dental supplemental payments, among other changes:

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Enhanced Cost-Based Prospective Alternative Payment Methodology

How is each FQHC's unique encounter rate calculated? How is the encounter rate adjusted over time?

Prospective Cost-Based APM:	Initial Rate Development:	Rate Enhancement:	Rebase Every Three Years:	Annual Inflationary Adjustments:	Other Adjustments:
Replace cost-settled APM with new prospective cost-based APM encounter rate, eliminating annual settlements.[1]	Allowable cost per encounter calculated from FQHC's FY2021 Cost Report, excluding Pharmacy and hospital-based physician services	FQHC allowable cost-per-encounter rates increased by 13% during each rebase cycle.	Encounter rate rebased every three years using full Medicaid FQHC cost report submission. Effective dates of FQHC rates will follow State Fiscal Year (July thru June).	Between rebasing, inflate encounter rate by the greater of the FQHC Market Basket or the medical component of Consumer Price Index.	Between rebasing, rates may be adjusted prospectively due to a change in scope of services request submitted by Feb. 28 to be effective July 1.

Encounter Definition & Claims Adjudication

Which services are eligible for encounter rate reimbursement? How are FQHCs reimbursed for services they currently bill fee-for-service?

Eligible Billing Codes for Encounter Rate	Dental	Pharmacy	Ancillary Services:
T1015 99381EP-99385EP 99391EP-99395EP Dental: Not code-specific; one dental encounter per beneficiary per day regardless of volume of services.	Claims initially adjudicate at fee schedule as they do today. Medicaid will pay a quarterly wraparound payment to make FQHCs whole to encounter rate.[2]	Carved out of encounter rate. Billed & reimbursed separately according to State Plan (i.e. acquisition cost and dispensing fee).	No separate reimbursement; costs are built into encounter rate. Claims adjudicate at $0. Like pharmacy services, hospital-based physician services and diagnostic lab services are excluded from APM & paid separately FFS.

Initial Claims Adjudication & Supplemental Wraparound Payments

How are claims reimbursed under Managed Care vs. Medicaid Direct? How and how often are FQHCs made whole to encounter rate?
How are the costs of FQHC services included in PHP capitation rates?

Encounter Claims Adjudication		Process for Wraparound Payments	Frequency of Wraparound	PHP Capitation
Medicaid Direct (i.e. Fee-for-Service): Reimbursed at the encounter rate. (Dental excepted, per above)	***Managed Care:*** PHPs reimburse at interim rates of $117.32 for T1015 and fee schedule rates for Health Checks.	PHPs pay wraparound payments to make FQHCs whole to APM encounter rate. DHHS reimburses PHPs directly outside of capitation. Quarterly wraparound process eliminated.	Starting July 2024, PHPs will make real-time wraparound payments. DHHS makes payments to reconcile FQHC claims dating back to July 2023.	Capitation payments to PHPs would be lowered due to market-based initial encounter rates for FQHCs compared to status quo.

[1] Cost report submissions will be required only once every three years for future APM rate rebasing; no reconciliation or cost settlement will take place.
[2] FQHCs will not be placed into repayment scenarios due to dental wraparound. If fee schedule payments exceed encounter rate, FQHCs <u>will not</u> owe back to NC Medicaid.

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What's Next for APM? Phased Implementation

Timeline	What to Expect Under Phased Implementation of new APM under State Plan Amendment approved ~~March 28~~ June 6
~~Next 30 Days~~	• Receive rate letters • Receive enhanced rates on Q2 wrap payments • Enhanced rates for Medicaid Direct claims starting May 1
~~Next 60 Days~~	• Receive enhanced rates on Q3 wrap payments • PHPs begin testing for real-time wraps
~~Next 90 Days~~ Next 30 days	• July 1 launch of real-time managed care wraps • Tailored Plans launch without real-time wraps • Medicaid decides on timeline for pulling SFY2023 claims to conduct final reconciliation to APM rates retro to July 2023
More than ~~90~~ 30 Days	• Receive enhanced rates on Q4 wrap payments • Receive annual reconciliation payments for enhanced rates retroactive to July 2023, **incl. for Q1** • Tailored Plans delay implementation of real-time FQHC wraparound payments • Rolling: Any outstanding Cost Settlements for prior fiscal years
TBD	• Medicaid begins making quarterly supplemental payments for dental services

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What to Expect: ~~Next 30 Days~~ Done

Timeline	What to Expect Under Phased Implementation of new APM under State Plan Amendment approved March 28
Next 30 Days	• Wrap payments for Q2 (Oct.-Dec 2023) at new rebased, enhanced rates (starting April 9) • Rate letters emailed to each FQHC detailing new rates for state fiscal year 2023 and SFY2024 (including inflationary increase) ◦ Email from Layth Salman (layth.salman@dhhs.nc.gov) • Starting May 1, Medicaid Direct (i.e. non managed care) claims paid at full APM rates for Core Services (T1015) and Well Child Checks (99381EP-99385EP; 99391EP-99395EP)

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What to Expect: ~~Next 60 Days~~ Done-ish

Timeline	What to Expect Under Phased Implementation of new APM under State Plan Amendment approved March 28
Next 60 Days	• Wrap payments for Q3 (Jan.-March 2024) at new rates. • Medicaid working with NCCHCA to determine timing to extract data. Aiming for extraction late April or early May in order to process payments in mid or late May • Prepaid health plans begin end-to-end testing for real-time wrap payments on June 3

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What to Expect: Next ~~90~~ 30 Days and Beyond

Timeline	What to Expect Under Phased Implementation of new APM under State Plan Amendment approved March 28
Next 90 Days	• Managed care real-time wraparound payments from Standard Plans scheduled to launch on July 1 • Real-time wrap payments will not be made by Tailored Plans when they launch on July 1 • Medicaid to decide, with input from NCCHCA, on cutoff date after June 30 to pull annual claims dating back to July 2023 and conduct final reconciliation payment to APM rates
More than 90 Days	• Medicaid completes wrap payments for Q4 (April-June 2024) • Medicaid to complete annual reconciliation payments retroactive to July 2023, **including reconciling Q1 payments to new APM rates (i.e. this is when FQHCs will be made whole to new rates for Q1 because Medicaid already conducted a quarterly wraparound payment for this quarter under the old rates)** • Target date of October 1 for Tailored Plans to implement real-time wraparound payments to FQHCs • Rolling: Any outstanding Cost Settlements for prior fiscal years
TBD	• Medicaid begins making quarterly supplemental payments for dental services

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Alternative Payment Model (APM)
Issue Addressed: Simplification - Reduced Administration Burden

- Narrows gap between “active” PPS rate and cost
  - **Carve out - Pharmacy**
    - Pharmacy will be carved out of the PPS rate; reducing complexity of cost reporting and adverse financial impact
  - **Less frequent cost reporting**
    - Every three years to support tri-annual rebasing
  - **One FQHC specific rate**
  - **Alignment of rate setting timeline with State Fiscal Year (SFY)**
    - PHPs update rates once per year

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Proposed FQHC Reimbursement Methodology: **What Differs and What Stays the Same**

While the overall structure for the proposed FQHC reimbursement methodology significantly differs from the existing approach, many key components are consistent with the current methodology.

Methodology Component	Differs from Current Approach	Aligns with Current Approach
Rate Methodology & Treatment Pharmacy	• Prospective cost-based rate, rather than retrospective cost-settled rate • Encounter rate of approximately 113% of allowable costs, rather than 100% (i.e., 13% rate increase) • Pharmacy carved *out* of encounter rate	• Use of FQHC cost reports to develop FQHC-specific encounter rate • Inclusion of both medical and dental costs in encounter rate development • Ability to request a change in scope of services to adjust the encounter rate
Encounters & Claims Adjudication	• FQHCs receive full encounter rate for all eligible encounters to ease administrative burden and support predictable FQHC cash flow *(funds flow process differs in managed care vs. FFS; see slide slides 9-10)*	• Definition of an encounter (i.e., which billing codes "trigger" an encounter payment)
PHP Capitation Rate Development	• Prospective PHP capitation rate would be lowered to reflect "market-based" initial rate	
Payment Timing & Reconciliation	• No annual reconciliation required	

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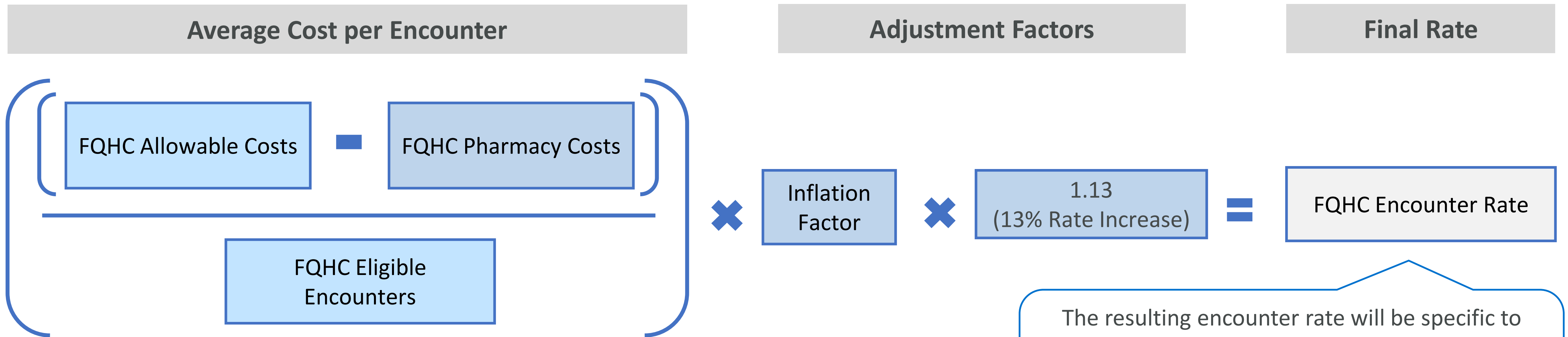
Reminder:

Calculating the Prospective, Cost-Based Encounter Rate

DHHS will calculate each FQHC's prospective cost-based encounter rate every three years, taking into account FQHC-specific costs and service mix. Due to the 13% rate increase above cost, per-encounter rate is likely to exceed payment under current state.



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Reminder:
Calculating the Prospective, Cost-Based Encounter Rate (continued)

Between "rebasing" years, FQHCs will benefit from inflationary increases and can request change in scope of services, if needed. Since this builds on the prior year's encounter rate, the 13% rate increase is already applied.

Adjustments Between Rebasing Years

Prior Year FQHC Encounter Rate *(includes 13% rate increase)* × Inflation Factor = FQHC Encounter Rate

Key

Aligns with current approach

Differs from current approach

Same as current state, qualifying events for a change in scope of service include changes in type, duration, or amount of services and Medicaid patients served. Unlike current methodology, change in scope would be applied prospectively to following year's rate (there would not be retrospective adjustments).

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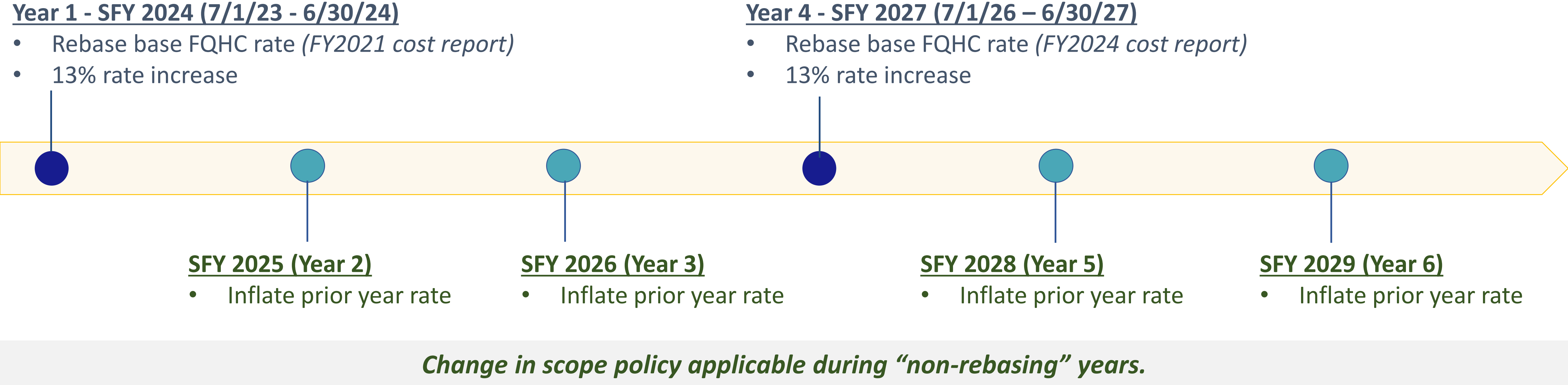
Timeline:
Rebasing and Non-Rebasing Years

The below timeline illustrates how FQHC encounter rates are updated on an annual basis. As noted, between rebasing years, FQHCs can request an adjustment to their encounter rate for a change in scope of services.



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Notes of Interest in Rate Development Timeline

Rates Aligned with State Fiscal Year (July thru June)

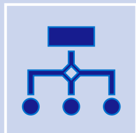
All FQHCs’ rates will be aligned with the SFY instead of FQHC fiscal year

But FQHC fiscal year is still the rate-setting year for future rebases

Inflationary adjustments

Rates adjusted each SFY by factor = greater of FQHC Market Basket Adjustment less Productivity Adjustment or CPI Medical Care

If FQHC FY does not align with SFY, the adjustment will be compounded based on month of FQHC FYE relative to SFY start



Change in Scope of Services opportunities

Outside of rebase years (FY2021, FY24, FY27, etc.), FQHC can submit once a year by March 31 for prospective adjustments to be made to rate by beginning of SFY (July)

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Our View:
Key Benefits

- Significantly improve cash flow and wraparound payment timeliness – real time?
- Remove barriers to FQHC success in value-based arrangements
- Remove incentives for PHPs to steer patients away from FQHCs
- Simplify and streamline Medicaid reimbursement methodology for FQHCs
- Continually update rates with more recent costs thru regular rebasing based on allowable cost
- Enhance rates 13% above cost
- Remove volatility of pharmacy reimbursement
- Eliminate/reduce risks of paybacks and reprocessed claims

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Contact

Forvis Mazars

David Fields, CPA
Partner
P: 417.865.8701
david.fields@us.forvismazars.com

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