NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

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M E M O R A N D U M

TO: Mandy Cohen, MD, MPH
Secretary

FROM: Dave Richard DS DR
Deputy Secretary for NC Medicaid

SUBJECT: State Plan Amendment
Title XIX, Social Security Act
Transmittal #2021-0016

DATE: September 14, 2021

Please find attached an amendment for North Carolina's State Plan under Title XIX of the Social Security Act for the Medical Assistance Program. The affected pages are Attachment 4.19-B, Section 2, Page 2c thru 2f.

This amendment is submitted pursuant to North Carolina Disaster State Plan Amendment (SPA) 20-0016 and will revise the methodology to include (a) an update to 2018 as the cost report base year for determining provider specific Prospective Payment System (PPS) rates and (b) adding an Alternative Payment Methodology (APM) in compliance with CMS Companion Letter to North Carolina Disaster Relief State Plan Amendment (SPA) 20-0016.

This amendment is effective July 1, 2021.

Your approval of this state plan amendment is requested. If you have any questions or concerns, please contact me or Betty J. Staton at 919-527-7093.

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

2.c. Federally qualified health center (FQHC) services and other ambulatory services furnished by a federally qualified health center.

(1) Effective for dates of service occurring January 1, 2001 and after, FQHCs are reimbursed on a Prospective Payment System (PPS) rate.

(A) The initial rate is equal to 100 per cent of their Medicaid allowable costs of covered services provided during the center's fiscal years 1999 and 2000, adjusted to take into account any increase (or decrease) in the scope of services furnished during fiscal year 2001 by the FQHC (calculating the payment amount on a per visit basis).

(B) The center's average fiscal years 1999 and 2000 cost shall be calculated by adding the total reasonable costs together for fiscal year 1999 and fiscal year 2000 and dividing by the number of visits.

(C) A visit means a face-to-face encounter between an FQHC patient and any health professional whose services are reimbursed under the State Plan, which includes Core Service, Well Child (NC Health Check), and Dental visits.

(D) At the beginning of each center's fiscal year, subsequent to January 1, 2001, the PPS rates shall be increased by the percentage increase in the Medicare economic Index for primary care services and adjusted to take into account any increase (decrease) in the scope of services furnished during that fiscal year according to the provisions within subparagraph (2).

(E) In the case of any FQHC participating with a licensed Medicaid managed care organization, quarterly reconciliation will occur with supplemental payments made no less frequently than every four months to the center for the difference between the payment amounts paid by the managed care organization and the amount to which the center is entitled under the prospective payment system. A final annual reconciliation of any supplemental payments will be completed at the end of the FQHCs' fiscal year. The following payments made by a licensed Medicaid managed care organization to a participating FQHC shall be excluded from the State's calculation and reconciliation of supplemental payments under Managed Care: incentive or bonus payments, payments for care management, advanced medical home fees, and other payments unrelated to FQHC services and other ambulatory services furnished by the FQHC.

(2) At the beginning of each center's fiscal year, subsequent to January 1, 2001, the PPS rates shall be increased by the percentage increase in the Medicare Economic Index for primary care services and adjusted to take into account any increase (decrease) in the scope of services furnished during that fiscal year.

(A) A rate adjustment due to change in the scope of services must be supported by the preponderance of evidence by the provider.

(B) The Division of Health Benefits shall make rate adjustments due to change in the scope of services.

(C) The MEI rate adjustment shall take effect on the first day of the provider's fiscal year.

(D) Rates may also be adjusted to take into consideration reasonable changes in the industry's cost of service.

(3) FQHCs which are newly qualified after December 31, 2018, will have their initial rates established by reference to rates paid to other centers with similar scope of services and caseload in the closest geographical proximity. Unique rates will be established for newly qualified FQHCs according to subparagraph (3)(A) below. The unique rate in subsequent fiscal years shall be updated according to the same update methods reflected in subparagraph (2) above.

(A) The newly qualified FQHCs' unique rate will be established based on the average cost per visit established by their first two full twelve month cost reporting periods.
(B) FQHCs meeting the definition of newly qualified under subparagraph (3) which are in operation as FQHCs prior to July 1, 2021 will have their unique rates established based on the cost per visit established by their first full twelve month cost reporting period.

(4) If the Core Service Provider Number has a Change of Ownership, the new provider will be reimbursed under the PPS methodology established in paragraph (3) above. The following situations typically constitute a change of ownership:

(1) Asset sale or transfer: The sale or transfer of title and property to another party (that party can be a related, affiliated, subsidiary entity or a non-related entity) and a new EIN is established; or

(2) Partnership: The removal, addition, or substitution of a partner (unless the partners expressly agree otherwise as permitted by applicable State law) and a new EIN is established; or

(3) Corporation: The merger of a corporate entity that holds a Medicare contract into another corporate entity, or the consolidation of a corporate entity that holds a Medicare contract with one or more other corporations, resulting in a new corporate body and new EIN.

a. If one or more FQHC, all subsidiaries of a larger FQHC (a holding company), consolidate into a separate FQHC (a new legal entity with a new EIN), and the former FQHCs are fully dissolved, this constitutes a change in ownership for all consolidated FQHCs and the PPS rate shall be established as defined in paragraph (3) above.

b. If an FQHC acquires an FQHC or RHC and either of the acquired is dissolved, it shall absorb the EIN and rate of the acquiring FQHC.

Alternative Payments

(5) FQHC Cost Based Reimbursement – Alternate Payment Methodology.

(A) Effective for dates of service beginning July 1, 2021 and after, FQHCs reimbursed under this Alternative Payment Methodology will have a Prospective Payment System (PPS) rate that is established based on the methodology below:

1. Each FQHC's initial PPS rate for dates of service beginning July 1, 2021 shall equal 100 per cent of their Medicaid allowable costs of covered services provided during the center's 2018 fiscal year adjusted to take into account any increase (or decrease) in the scope of services furnished during the provider's full fiscal years 2019 and 2020 and increased by the percentage increase in the Medicare Economic Index for primary care services in 2019 and 2020 (calculating the payment amount on a per visit basis).

2. At the beginning of each center's fiscal year, subsequent to July 1, 2021, the PPS rates shall be adjusted according to the factors and processes outlined in subparagraph (2).

(B) Interim payments to FQHCs are based on the Medicaid Fee Schedule which consists of their provider specific Core Service Rate (T1015) identified in subparagraph (10) and the NC FQHC Physician Service Fee Schedule for all other ambulatory services.

(C) Services furnished by a federally qualified health center (FQHC) are reimbursed at one hundred percent (100%) of reasonable allowable cost, as determined in an annual cost report, based on Medicare principles and methods.

(1) Nutrition services are provided by RHC's and FQHC's. Providers are reimbursed in accordance with reimbursement methodologies established for services provided by RHC's and FQHC's as based on Medicare principles.

(2) Effective October 1, 1993, physician-provided services at a hospital inpatient and an outpatient location are paid at the existing fee-for-service rate only to those clinics whose agreement with their physician states that the clinic does not compensate the physician for services in a location other than at the federally qualified health clinic location.

(D) FQHC Providers reimbursed under this methodology shall file annual Medicaid cost reports as directed by the Division of Health Benefits in accordance with 42 CFR 413, Subpart b and 42 CFR 447.202. The cost report is due five (5) months after the provider's fiscal year end. The Division of Health Benefits will have 120 days after the receipt of the cost report to issue a tentative settlement of 75% of the balance due to the FQHC provider with a final settlement to be issued within eighteen (18) months of the date the full cost report is received.

(E) Cost Report Settlement Process:

(1) The Division annually reconciles the interim payments made to FQHCs to the provider's allowable reimbursement which is the greater of the provider's Medicaid allowable cost or what the provider would have received under their APM PPS rate determined in subparagraph (5)(A).

(2) If the provider's allowable reimbursement exceeds interim payments received, the Division will pay the difference to the provider. If the interim payments received by the provider exceed the provider's allowable reimbursement the provider shall remit the difference and the federal share will be returned via the CMS-64 report.

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

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(6) Enhanced Payments for Pregnancy Medical Home services will be made to FQHC providers as specified in Attachment 3.1-B, Page 7(a) and Attachment 3.1-F. The Pregnancy Medical Home will be paid these enhanced payments in additional to their regular reimbursement.

Two enhanced payments may be made to FQHCs for services provided by a Pregnancy Medical Home. Upon completion of the high risk screening, an enhanced payment of $50.00 will be made to the PMH. Upon completion of the recipient's post partum visit, an enhanced payment of $150.00 will be made to the PMH provider. The PMH provider will receive a maximum of $200 enhanced payments per recipient per pregnancy even if there are multiple births.

Additionally, the PMH provider receives an enhanced rate for a vaginal delivery by paying the same rate for the vaginal delivery as for an uncomplicated c-section. Only the physician rates for the delivery codes are enhanced. The enhanced rates were determined by applying a 13.2% increase to the NC Medicaid Physician Fee Schedule rate as established in Attachment 4.19-B Section 5, Page 1 of the State Plan.

There shall be no cost settlement for any provider in any setting for these services reimbursed at the enhanced rates.

Notwithstanding any other provision, if specified, these rates will be adjusted as shown on Attachment 4.19-B, Supplement 3, Page 1 of the State Plan.

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Alternative Payments

(7) FQHC PPS APM Reimbursement – Alternate Payment Methodology (APM).

(A) Effective for dates of service beginning July 1, 2021 and after, FQHCs reimbursed under this Alternative Payment Methodology will have a Prospective Payment System (PPS) rate that is established based on the methodology below:

1. Each FQHC's initial PPS rate for dates of service beginning July 1, 2021 shall equal 100 per cent of their Medicaid allowable costs of covered services provided during the center's 2018 fiscal year adjusted to take into account any increase (or decrease) in the scope of services furnished during the provider's full fiscal years 2019 and 2020 and increased by the percentage increase in the Medicare Economic Index for primary care services in 2019 and 2020 (calculating the payment amount on a per visit basis).
2. At the beginning of each center's fiscal year, subsequent to July 1, 2021, the PPS rates shall be adjusted according to the factors and processes outlined in subparagraph (2).

(B) Interim payments to FQHCs are based on the Medicaid Fee Schedule which consists of their provider specific Core Service Rate (T1015) identified in subparagraph (10) and the NC FQHC Physician Service Fee Schedule for all other ambulatory services.

(C) FQHC Providers reimbursed under this methodology shall file annual PPS Reconciliation Report as directed by the Division of Health Benefits. The PPS Reconciliation Report is due five (5) months after the provider's fiscal year end.

(D) The Division annually reconciles the interim payments received to the amount owed under the provider's PPS APM reimbursement determined in subparagraph (7)(A). To ensure providers receive no less under the PPS APM reimbursement methodology than under PPS, the Division compares the amount owed under the provider's PPS APM reimbursement to what the provider would have received under PPS reimbursement determined in subparagraphs (1) and (2).

(E) If the provider's allowable reimbursement exceeds interim payments received, the Division will pay the difference to the provider. If the interim payments received by the provider exceed the provider's allowable reimbursement the provider shall remit the difference and the federal share will be returned via the CMS-64 report.

Alternative Payments

(8) In the case of any FQHC receiving Alternative Payment Methodology reimbursement as established in subparagraph (5) or (7) which is participating with a licensed Medicaid managed care organization, quarterly reconciliation will occur with supplemental payments made no less frequently than every four months to the center for the difference between the payment amounts paid by the managed care organization and the amount to which the center is entitled under the APM PPS rate (subparagraphs (5)(A) and (7)(A), respectively) established in those respective subparagraphs. A final annual reconciliation of any supplemental payments will be completed at the end of the FQHCs' fiscal year. The following payments made by a licensed Medicaid managed care organization to a participating FQHC shall be excluded from the State's calculation and reconciliation of supplemental payments under Managed Care: incentive or bonus payments, payments for care management, advanced medical home fees, and other payments unrelated to FQHC services and other ambulatory services furnished by the FQHC.

(9) Alternate Payment Methodology Election

(A) Established FQHC Providers as of July 1, 2021 and which do not qualify as new FQHC providers under Section (3) shall have 30 days from approval of State Plan Amendment #21-0016 to elect to be reimbursed under an Alternate Payment Methodology described in paragraph (5) or (7) and they shall remain with that election beginning July 1, 2021.

(B) New FQHC providers under Section (3) shall have 30 days from date of enrollment to elect to be reimbursed under Alternate Payment Methodology described in paragraph (7).

(C) New FQHC providers under Section (3) shall have 30 days from date of receipt of their unique provider rates to elect to be reimbursed under an Alternate Payment Methodology described in paragraph (5) or (7) and they shall remain with that election beginning with the date of that election.

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(10) Interim payment rate for Core Services (T1015)

A provider specific Core Service rate (T1015) is established using the CMS FQHC cost reporting schedules (CMS 222-92 / CMS 224-14) plus North Carolina Medicaid supplemental schedules. The Core Service rate is intended to approximate 100% of Medicaid allowable cost per visit for Core Services plus the difference between Medicaid allowable cost and Medicaid interim payments for other ambulatory services on a per visit basis in order to minimize the wrap payment to providers under an Alternate Payment Methodology. At the beginning of each provider's fiscal year, the Core Service rate is increased by the percentage increase in the Medicare Economic Index for primary care services and adjusted to take into account any increase (or decrease) in the scope of services. The provider specific Core Service rates effective March 31, 2020 are identified at **https://medicaid.ncdhhs.gov/providers/fee-schedules**.

For Date of Service beginning July 1, 2021, newly qualified FQHC's shall have their interim Core Service rates established by reference to rates paid to other centers with similar scope of services and caseload in the closest geographical proximity. The newly qualified FQHC's unique Core Service rates will be established based on their first two full twelve month cost reporting periods based on the following methodology using the CMS 224-14 cost reporting schedules (or their successor) plus North Carolina Medicaid supplemental schedules (or their successor)

1. Identify Core Service Cost Rate from CMS 224-14, Worksheet B, Part I
2. Determine Total Medicaid Core Service Cost by multiplying Total Medicaid Core Service paid visits by Core Service Cost Rate
3. Determine Total Medicaid Net Non-Core Service Cost as follows:
    a. Subtract Total Medicaid Core Service Cost from Total Medicaid Reimbursable Cost which includes cost for all other ambulatory services to determine Total Medicaid Non-Core Service Cost
    b. Subtract Total Medicaid Payments received for Non-Core Services
4. Determine Cost per visit for Medicaid Net Non-Core Service Cost by dividing Medicaid Net Non-Core Service Cost by total Medicaid visits for Core Services
5. Sum the Core Service Cost Rate plus the Cost per visit for the Medicaid Net Non-Core Service Cost to determine the provider specific Medicaid Core Service (T1015) rate.