NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
JAY LUDLAM • Deputy Secretary, NC Medicaid

SIGNATURE REQUEST MEMORANDUM

TO: Jay Ludlam DS

FROM: Betty J. Staton, SPA Manager

RE: State Plan Amendment

Title XIX, Social Security Act
Transmittal #2023-0022

Purpose
Attached for your review and signature is a Medicaid State Plan amendment summarized below, and submitted on September 15, 2023, with a due date of September 18, 2023.

Clearance
This amendment has been reviewed for both accuracy and completeness by:

Betty J. Staton, Emma Sandoe, Melanie Bush, Lotta Crabtree, Adam Levinson

Background and Summary of Request
It is recommended that you sign this State Plan Amendment submission per Centers for Medicare and Medicaid Services (CMS) protocol as head of the Single State Agency administering the Medicaid program.

- Please find attached a State Plan Amendment (SPA) that implement a new Prospective Payment System (PPS) Alternate Payment Methodology (APM) which will (a) establish a cost based PPS APM rate that is rebased triennially beginning with the 2021 cost report period and utilizing 113% of Medicaid allowable cost (in continuation of SPA 22-022), (b) change the non-base year inflation factor from the Medicare Economic Index (MEI) to the greater of the FQHC Market Basket Index or CPI Medical Index, and (c) enable real time wrap payments from Managed Care entities to the FQHC Providers. This revision is intended to support FQHC's financial viability in the face of increased costs and to strengthen North Carolina's array of safety net medical care providers.

The proposed effective date is July 01, 2023.

Your approval of this State Plan Amendment is requested. If you have any questions or concerns, please contact me at (919) 538-3215.

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

(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 subparagraph (3) above. The following situations typically constitute a change of ownership:

(A) 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

(B) 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

(C) 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.

1. 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 subparagraph (3) above.

2. 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.

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Alternative Payments

(5) 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.

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.

Alternative Payments

(6) FQHC Alternate Payment Methodology (APM) Reimbursement.

(A) Effective for dates of service beginning July 1, 2023 and after, FQHCs Reimbursed under this APM will receive a single APM per visit rate for all eligible encounters. Eligible encounters include the following:

1. Core Services (T1015)
2. Well Child Visits (99381EP-99385EP, 99391EP-99395EP)

(B) The APM per visit rate for each individual FQHC will be determined triennially each July 1st based on the following methodology:

1. For the first year of each triennial period:
    a. Sum total of Medicaid allowable costs for covered services from the FQHCs full fiscal year Medicaid cost report of the second prior calendar year (e.g., the provider's fiscal year end 2021 cost report shall serve as the basis for the APM rate beginning July 1, 2023). Medicaid allowable costs for purposes of calculating the APM rate shall exclude the following costs:
        i. Pharmacy services;
        ii. Physician-provided services at a hospital inpatient and outpatient location.
    b. Divide Medicaid allowable cost by the total number of Medicaid face to face encounters (Core Service, Well Child (NC Health Check), and Dental visits) to determine a base year Medicaid cost per encounter.
    c. Inflate the base year Medicaid cost per encounter amount from the prior step to July 1st of the current year by compounding the months between the end of the fiscal year for the FQHC's cost report (as described in subparagraph (6)(B)1.a) through July 1st of the current year. The inflationary factor shall be the greater of:
        i. The Medicare FQHC Market Basket; or
        ii. The Consumer Price Index (CPI) for medical care.
    d. Multiply the Medicaid cost per encounter from the prior step by one and thirteen one hundredths (1.13).

2. Annually on July 1st for the second and third years of each triennial period:
    a. Adjust the previous year's APM rate to account for any increase (or decrease) in the scope of services in the FQHCs full fiscal year Medicaid cost report of the second prior calendar year (e.g., APM rates beginning July 1, 2024 shall consider changes in scope of service from the provider's Medicaid cost report period ended in calendar year 2022); and
    b. Inflate the amount by the greater of:
        i. The Medicare FQHC Market Basket; or
        ii. The CPI for medical care.

3. In the first year of all subsequent triennial periods, each FQHC's APM rate shall be established based on the process described in subparagraph (6)(B)1. For the second and third year of all subsequent triennial periods, each FQHC's APM rate shall be established based on the process described in subparagraph (6)(B)2.

4. FQHC's that are newly qualified or fail to submit a cost report by the beginning of the triennial period will preliminarily receive a "like provider" APM rate established by reference to rates paid to other FQHCs with a similar scope of services and caseload in the closest geographical proximity.
    a. FQHCs meeting these criteria will default to a like provider APM rate but will have the opportunity to elect the PPS rate described in subparagraph (1).
    b. For FQHCs that submit a full 12 month Medicaid cost report by March 1 of a year during the triennial period, the Division will calculate a center-specific APM rate to be applied on a prospective basis beginning with the start of the next state fiscal year.
    c. FQHCs that submit the required cost report during the triennial period will remain subject to the same triennial cycle as other FQHCs in subsequent years (i.e., submitting a cost report in the middle of a triennial period does not start a unique triennial period for that FQHC; the FQHC would still be required to submit a subsequent cost report within the same timeframe as other FQHCs prior to the start of the next statewide triennial period).

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

(C) Reimbursement processes

1. For the period of July 1, 2023 through December 31, 2023, FQHCs shall continue to be reimbursed using the payment methodology in effect on June 30, 2023. At the conclusion of the July 1, 2023 to December 31, 2023 period, the Division shall make a lump sum payment to each FQHC equal to the difference between what each FQHC would have received under the APM rate (as calculated in subparagraph (6)(B)) for the same services and actual payments made during the July 1, 2023 through December 31, 2023 period.

2. Beginning January 1, 2024, FQHCs shall be reimbursed as follows:
    a. For managed care enrollees, managed care organizations shall pay FQHCs:
        i. An interim rate of one hundred seventeen dollars and thirty two cents ($117.32) for each encounter for Core Services (T1015) and an interim rate of the applicable Medicaid fee schedule rate for Well Child Visits (99381EP-99385EP, 99391EP-99395EP) upon initial claims adjudication.
        ii. Supplemental wraparound payments equal to the difference between the interim rate and the APM rate. Managed care organizations shall make supplemental wraparound payments upon initial claims adjudication. Calculations of the supplemental wraparound payments shall not include as offsets any payments made other than the interim rate.

iii. Payments that will not count as offsets against the supplemental wraparound payment calculation include, the following:
   1. Medicaid Fee Schedule rates for pharmacy services, including applicable acquisition costs and dispensing fees;
   2. The applicable fee-for-service rate for physician-provided services furnished at a hospital inpatient and outpatient location;
   3. Shared savings, incentives or other bonus payments;
   4. Medical home fees;
   5. Care management fees; and
   6. Pregnancy Medical Home payments.
   7. Additional payment streams established by the Department or Prepaid Health Plans other than the interim rates described under 2(a)(i)

iv. The Division shall reimburse managed care organizations monthly for costs associated with supplemental wraparound payments to FQHCs (as described in subparagraph (6)(C)(2)a.ii).

b. For fee-for-service enrollees, the Division shall pay FQHCs:
   i. The APM rate for each encounter for Core Services (T1015) and Well Child Visits (99381EP-99385EP, 99391EP-99395EP).
   ii. Medicaid Fee Schedule rates for pharmacy services, including applicable acquisition costs and dispensing fees. Pharmacy services shall be reimbursed separately from the APM rate.
   iii. The applicable fee-for-service rate for physician-provided services provided at a hospital inpatient and outpatient location. These services shall be reimbursed separately from the APM rate.
   iv. Medicaid Fee Schedule rates for dental services plus quarterly supplemental wraparound payments up to the APM rate for each dental claim, up to a limit of one claim per day.
      1. The Division shall reimburse FQHCs/RHCs for dental claims on an interim basis at the applicable Medicaid Fee Schedule rate upon adjudication.

2. At the conclusion of each quarter, the Division shall calculate the difference between (1) total interim dental claim payments during the quarter and (2) the number of dental claim encounters (up to a maximum of one per day per enrollee) multiplied by the FQHC's APM rate. If the total amount owed under the APM reimbursement is greater than total interim dental claim payments, the Division shall make a supplemental wraparound payment to the FQHC for the amount. If the total amount owed under the APM reimbursement is less than or equal to total interim dental claim payments, no supplemental wraparound payments shall be made.

v. Pregnancy Medical Home payments (as applicable).

(D) To ensure providers receive no less under the APM reimbursement methodology than under PPS, the Division compares the amount owed under the provider's APM reimbursement to what the provider would have received under PPS reimbursement described in subparagraph(1).

Alternative Payments

(8) Alternate Payment Methodology Election

(A) Established FQHC Providers as of July 1, 2023 and which do not qualify as new FQHC providers under subparagraph (3) shall have 30 days from approval of State Plan Amendment #23-0022 to elect to be reimbursed under PPS or the APM methodology described in subparagraph (6) and they shall remain with that election beginning July 1, 2023.

(B) New FQHC providers under subparagraph (3) shall have 30 days from date of enrollment to elect to be reimbursed under PPS or the APM methodology described in subparagraph (6).

(C) New FQHC providers under subparagraph (3) shall have 30 days from date of receipt of their unique provider rates to elect to be reimbursed under PPS or APM methodology described in subparagraph (6) and they shall remain with that election beginning with the date of that election.

(D) FQHCs that do not make an election within the required timeframe will be defaulted to the APM methodology described in subparagraph (6). Such FQHCs may elect to switch to the PPS methodology at any time.

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