Rural Health Clinic

Medicaid Payment Methodologies

Oregon Health Authority

April 2022

Agenda

- Rural Health Clinic (RHC) information
  - Oregon Administrative Rules (OARs) Division 410, Chapter 147
  - Federally Qualified Health Centers and Rural Health Clinics Program
- RHC payment methodologies
  - Prospective Payment System (PPS) encounter rate calculation and process
  - Alternative Payment and Advanced Care Model (APCM)
- APCM participation

OARs and Program

RHC INFORMATION

RHC OAR Division 410, Chapter 147

FQHC AND RHC SERVICES

410-147-0120 Division Encounter and Recognized Practitioners

410-147-0320 Federally Qualified Health Center Rural Health Clinics Enrollment

410-147-0340 Federally Qualified Health Centers and Rural Health Clinics Provider Numbers

410-147-0360 Encounter Rate Determination

410-147-0362 Change in Scope of Services

410-147-0365 Rural Health Clinic Obstetrics Care Delivery Procedures Reimbursement

410-147-0460 Prepaid Health Plan Supplemental Payments

410-147-0480 Cost Statement Instructions

410-147-0500 Total Encounters for Cost Reports

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FQHC and RHC Program

Federally Qualified Health Centers and Rural Health Clinics Program

- Current Oregon Administrative Rules (OARs)
- Recent rule filings
- Supplemental information and guidelines
- Alternative Payment and Advanced Care Model (APCM)
- Oregon Medicaid prior authorization (PA) criteria
- Preferred Drug List
- Forms
- Policy Quick Links
  - FQHC/RHC Quick Links
  - 340B Program
  - CCO Wraparound Payments

PPS v. APCM

RHC PAYMENT METHODOLOGIES

RHC Reimbursement

- Oregon's Medicaid State Plan
- PPS encounter rate for valid encounters (OHP Plus)
- Fee schedule for
  - Cover All Kids (CAK)
  - Healthier Oregon Program (HOP), beginning 7/1/2022
  - Citizenship-Waived Medical (CWM) or
  - Qualified Medicare Beneficiaries (QMBs)
- Supplemental (Wraparound) Payment
- APCM reimbursement
  - PPS rate converted into per-member per-month (PMPM) rates
  - Medical services only (behavioral health may come later)
  - Medical encounters pay $0

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PPS Encounter Rate

- Allowable costs / Allowable visits = encounter rate
  - May be the same for all types of services
  - Some clinics have different rates for medical, dental, and/or behavioral health
- RHC cost reporting for PPS
  - FQHC/RHC Cost Worksheet (OHP 3027), or
  - Medicare Cost Report (CMS 222-17)

Rate-setting Process

1. Submit cost report to Safety Net Clinics Program Manager – RHCs may use either the Medicare Cost Report or the FQHC/RHC Cost Statement (OHP 3027) – There are additional items required, some are specific to submitting the OHP 3027 (see OAR 410-147-0320 (5) and 410-147-0360 (3))
2. Safety Net Clinics Program Manager, along with actuaries at OHA, review the cost report and determine a PPS encounter rate and/or APCM PMPM rates for the clinic – Sometimes there is some back and forth between the clinic and OHA staff which could lengthen the process
3. Safety Net Clinics Program Manager sends the clinic a Preliminary Rate Notification containing the proposed PPS encounter rate (preliminary because OHA's budget team may take some time to review the rate; with clinic agreement, OHA can implement the preliminary rate during that process)
4. Clinic agrees/disagrees with the preliminary rate in writing (email is sufficient)
5. OHA implements the rate upon clinic enrollment with an effective date that coincides with the date the rate was determined.

APCM PMPM Rates

- PPS encounter rate converted into equivalent PMPMs
  - "Wrap Cap" for members assigned to CCOs
  - Fee-for-service (FFS) for members not assigned to CCOs
- PMPM calculation based upon the clinic's medical PPS encounter rate and historical patient utilization
  - Medical PPS rate = $100/encounter
  - Medicaid patients = 5,000 at an average of 3.0 medical encounters per patient (15,000 encounters; $1.5 million revenue)
  - Medical revenue/medical encounters ($1,500,000/5,000) = $300 per patient, per year
  - PMPM: $300/12 months = $25 PMPM

APCM in MMIS – Provider File

Encounter Group Rate

Encounter Group Rate Top Nav

Pricing Indicator	Pricing Indicator Description	Group Rate	Effective Date	End Date	Inactive Date
ENCMH	FQHC/RHC Enc Mental	$173.32	01/01/2022	12/31/2299	12/31/2299
ENCDEN	FQHC/RHC Enc Dental	$173.32	01/01/2022	12/31/2299	12/31/2299
ENCTOB	FQHC/RHC Enc Tobacco	$0.00	01/01/2017	12/31/2299	12/31/2299
ENCMED	FQHC/RHC Enc Medical	$0.00	01/01/2017	12/31/2299	12/31/2299
ENCAD	FQHC/RHC Enc Addiction	$173.32	01/01/2022	12/31/2299	12/31/2299
ENCMCM	FQHC/RHC Enc MCM	$173.32	01/01/2022	12/31/2299	12/31/2299

Customary Charge

Customary Charge

Procedure	Modifier 1	Modifier 2	Modifier 3	Modifier 4	UCC Rate	Rate Type	Effective Date	End Date
0003A	U1				$176.97	Default	01/01/2022	12/31/2299
0013A	U1				$176.97	Default	01/01/2022	12/31/2299
91305	U1				$176.97	Default	01/01/2022	12/31/2299
0051A	U1				$176.97	Default	01/01/2022	12/31/2299
0052A	U1				$176.97	Default	01/01/2022	12/31/2299
0053A	U1				$176.97	Default	01/01/2022	12/31/2299
0054A	U1				$176.97	Default	01/01/2022	12/31/2299
91307	U1				$176.97	Default	01/01/2022	12/31/2299
0071A	U1				$176.97	Default	01/01/2022	12/31/2299
0072A	U1				$176.97	Default	01/01/2022	12/31/2299

1 2 3 4 5 6 7 8 9 10 ... Next >

APCM in MMIS – Capitation (PMPM)

Capitation Rate

Capitation Rate Override Top Nav

Region **End Date**

MC Region	Capitation Category	Capitation Amount	Effective Date	End Date
APM1E Alternate Payment Methodology	APM FFS	$35.94	01/01/2022	12/31/2299
APM1E Alternate Payment Methodology	APM Physical Health	$30.29	01/01/2022	12/31/2299

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APCM Payment Process – PMPM

- Medicaid members are assigned to the clinic using the Patient Upload Template (OHP 3131)
  - Day-One List (initial upload) may include Medicaid members with a valid encounter within the preceding 18 months
  - After the Day-One List, clinics upload the OHP 3131 to add Medicaid members with valid encounters within the preceding 12 months
- MMIS pays PMPMs during the first capitation cycle of each month: Wrap Cap and FFS
- PMPM payments are reported on the electronic 820 file
  - Clinics must complete a Trading Partner Agreement (TPA) to receive electronic files (Electronic Data Interchange)
  - Clinics must sign up for the 820 file

APCM Payment Process – Claims

- MMIS routes payment for each claim based upon the diagnosis code (medical, behavioral health, or dental)
- Payable claims with medical diagnosis
  - Some medical procedures are carved out of the APCM (e.g., obstetrical services, COVID-19 vaccinations, etc.) and are paid at the PPS rate
  - Payable medical claims for carved-in services receive a “Paid” status and pay $0
- Payable claims with behavioral health or dental diagnosis pay at the clinic’s PPS rate

APCM Payment Process – Supplemental

- Supplemental (wraparound) payment still applies for Medicaid members assigned to the APCM-participating clinic
- Supplemental (wraparound) payment is only paid for services carved out of the APCM (e.g., obstetrics care, behavioral health, dental, etc.)
- The supplemental (wraparound) process has not changed
- APCM-participating clinics are responsible to ensure only eligible encounters are reported on the supplemental (wraparound) report

APCM Payment Process – Reconciliation

- Quarterly reconciliation
  - Intended to ensure clinics are paid at least as much as they would be paid under the PPS
  - Clinic completes a quarterly reconciliation report comparing revenue earned under the APCM with revenue it would have earned under PPS
  - OHA reconciles with each clinic annually, based upon the quarterly reports, to make up any difference between APCM revenue and what the clinic would have received via PPS
  - The APCM clinic is not required to return dollars in excess of PPS
- APCM-participating clinics are responsible to ensure only eligible encounters are reported on the supplemental (wraparound) report

APCM Reconciliation Template – Page 1

Alternative Payment Methodolgy (APM) Reconciliation			
For the Period :			
PAYMENTS			
From the State			
820 Payments:			
OPEN CARD Client Capitation			
MANAGED CARE Client Wrap Payments			
	Subtotal		$ -
Fee for Service Payments:			
Cawem, QMB, etc.			
Carve Outs			
Incorrect claims (MH/OB)			
	Subtotal		$ -
From MCOs / CCOs			
Capitation Payments			
Fee for Service Payments			
	Subtotal		$ -
From Medicare / Commercial Payers			
Capitation Payments			
Fee for Service Payments			
	Subtotal		$ -
Total Payments.....			$ -

Reconciliation Template – APCM Participation Agreement, Attachment D

APCM Reconciliation Template – Page 2

EXCLUDED PAYMENTS		
From the State		
820 Payments:		
Unrecovered 820 Payments		
Fee for Service Payments:		
Prenatal / OB		
Dental		
Mental Health		
Services for Clients NOT enrolled in APM		
Clinic Sites/Services not in Scope		
Subtotal		$ -
From MCOs / CCOs		
Fee for Service Payments: (received for clients excluded from APM)		
Prenatal / OB		
Dental		
Mental Health		
Capitation Paid		
Services for Clients NOT enrolled in APM		
Clinic Sites/Services not in Scope		
		$ -
From Medicare / Commercial Payers		
Fee for Service Payments		
Prenatal / OB		
Dental		
Mental Health		
Services for Clients NOT enrolled in APM		
Clinic Sites/Services not in Scope		
		$ -
Total Excluded Payments.....		$ -
NET Payments for APM Clients (Total Payments less Excuded Payments)...		$ -

Reconciliation Template – APCM Participation Agreement, Attachment D

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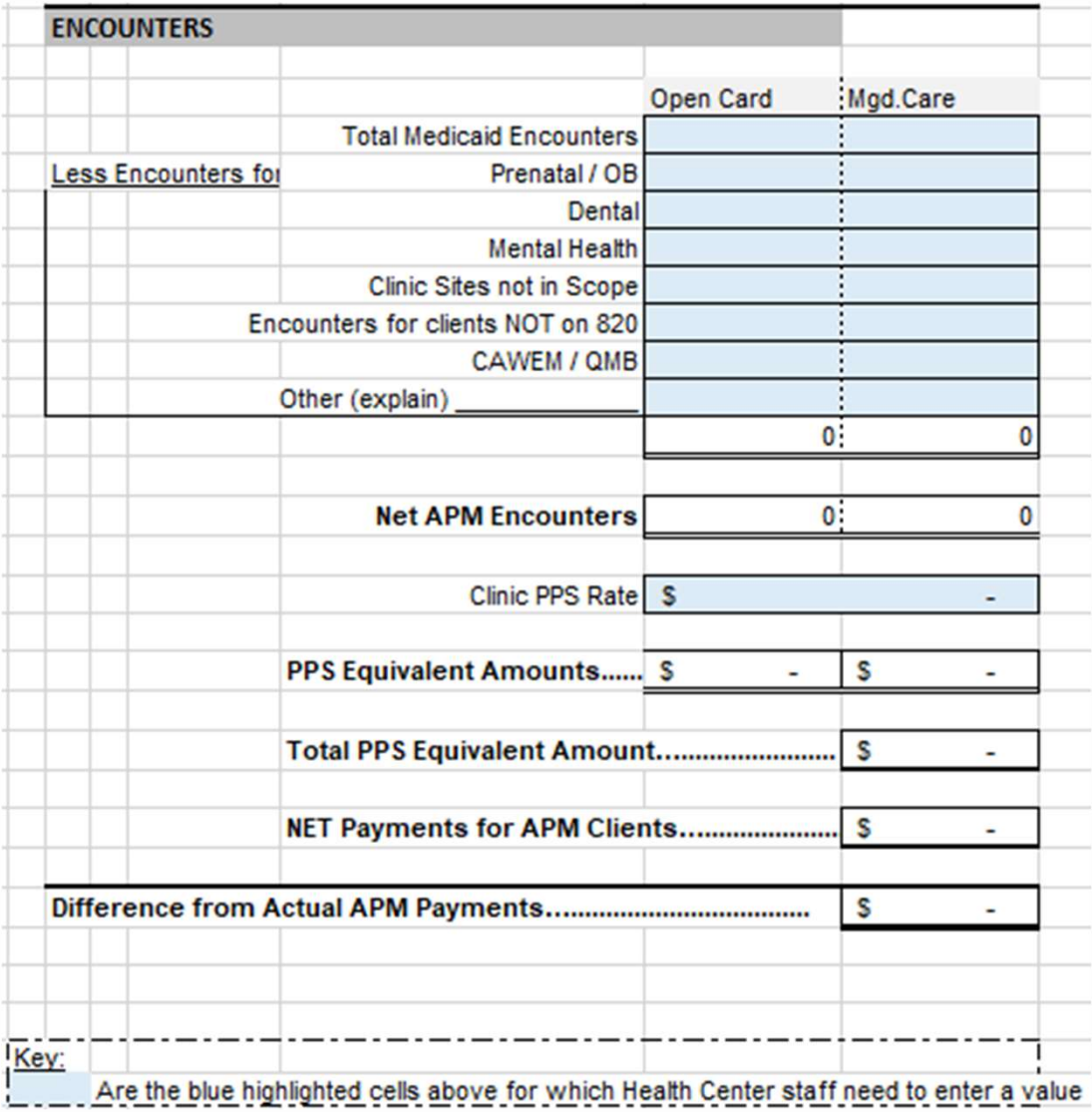
APCM Reconciliation Template – Page 3



ENCOUNTERS			
		Open Card	Mgd.Care
	Total Medicaid Encounters		
Less Encounters for	Prenatal / OB		
	Dental		
	Mental Health		
	Clinic Sites not in Scope		
	Encounters for clients NOT on 820		
	CAWEM / QMB		
	Other (explain) _____		
		0	0
	Net APM Encounters	0	0
	Clinic PPS Rate	$ -	
	PPS Equivalent Amounts.....	$ -	$ -
	Total PPS Equivalent Amount.....		$ -
	NET Payments for APM Clients.....		$ -
Difference from Actual APM Payments.....			$ -

Key:
Are the blue highlighted cells above for which Health Center staff need to enter a value

Agreement and Requirements

APCM PARTICIPATION

APCM Participation Agreement

- Terms of APCM-participation
- Agreed upon and signed and dated by clinic and OHA
- Contents include (Attachments A through G):
  - Oregon APCM Program Accountability Plan**
  - APCM Rate Methodology Worksheet
  - APCM Care STEPs**
  - Reconciliation Template
  - Attribution Policy
  - APCM Exclusion Agreement for Wrap Cap Reimbursement
  - Change-in-Scope Methodology for APCM

**Contain reporting requirements for clinics

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APCM Program Accountability Plan

Population Health Equity

Health centers will engage in segmentation, a process where health centers identify a population and use a tool to learn more about bio-psychosocial needs.

Cost

Defining and tracking total cost and utilization; Currently, total cost and utilization data is not consistently available to participating health centers.

OHA, OPCA, and clinics agree to:

- A process to clearly define what data should be tracked under the cost and utilization quadrant, including Emergency Room (ER) utilization.

- Work collaboratively to identify ways to access this data for CHCs to include Total Cost of Care, and an ER Utilization metric, among others. Until there is an agreed-upon definition of Total Cost of Care, health center will not be required to positively influence Total Cost of Care or be held to metrics related thereto.

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APCM Program Accountability Plan

Access

Health centers may use visits and/or Care STEPs, using any member of the care team, to keep a patient active in the APCM program.

OHA will remove from the APCM program, and stop issuing PMPM payments for, inactive patients.

Quality

**Health centers report annually:

- Required CCO measures for Medicaid patients at the health center and
- Two Patient Experience measures.

APCM Care STEPs

Services That Engage Patients (STEPs)

**Health centers document Care STEPs and report quarterly to OHA

New Visit Types

- Online Portal Engagement
- Health and Wellness Call
- Home Visit (Billable Encounter)
- Home Visit (Non-Billable Encounter)
- Advanced Technology Interactions

Education, Wellness and Health Promotion

- Care Gap Outreach
- Education Provided in Group Setting
- Exercise Class Participant
- Support Group Participant
- Health Education Supportive Counseling

Coordination and Integration

- Coordinating Care: Clinical Follow Up and Transitions in Care Settings
- Coordinating Care: Dental
- Behavioral Health and Functional Ability Screenings
- Warm Hand-Off

Reducing Barriers to Health

- Social Determinants of Health Screening
- Case Management
- Accessing Community Resource/Service
- Transportation Assistance

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APCM Rate Methodology Worksheet

Wrap Cap Data Request Template - Insert Health Center Name
For 12 Month Period: Insert Rate Setting Period

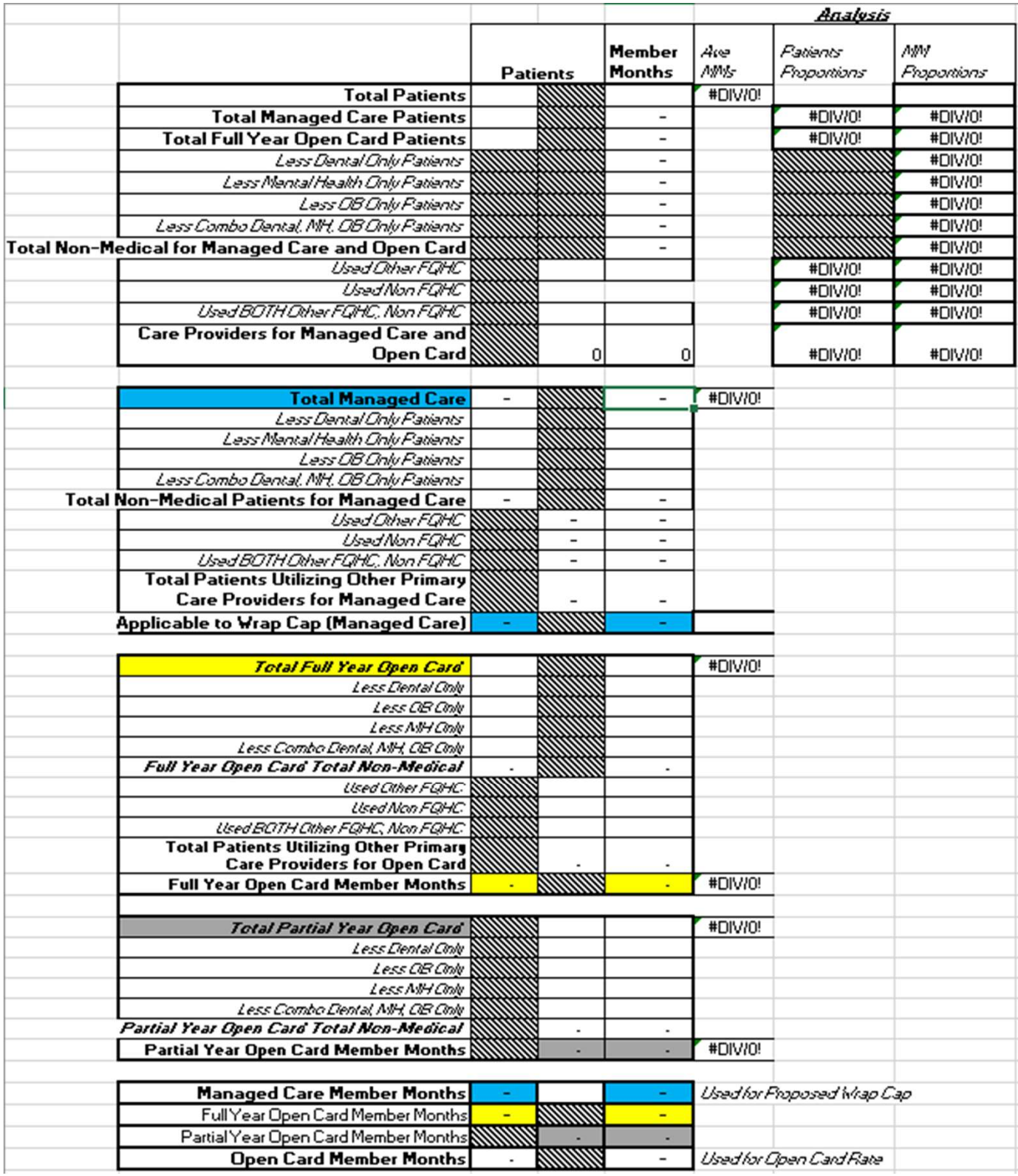
	MCO Payments	Wrap & Reconciliation Payments	Total Payments	Visits	*Effective Rates per Visits*
Payments for Managed Care Patients			$ -		#DIV/0!
Less OB payments			$ -		#DIV/0!
Less dental payments			$ -		#DIV/0!
Less mental health payments					#DIV/0!
Less Cover All Kids					
subtotal	$ -	$ -	$ -	0.00	#DIV/0!
Less services not included in PPS rate	$ -	$ -	$ -	-	-
Total Applicable Payments For MCO Patients	-	-	-	-	#DIV/0!
		State Payments	**Total Payments**	**Visits**	
Payments for Open Card Patients					#DIV/0!
Less OB payments					#DIV/0!
Less dental payments					#DIV/0!
Less mental health payments					#DIV/0!
Less Cover All Kids					
subtotal		$ -	$ -	$ -	#DIV/0!
Less CAWEM (does not include CAWEM+)		$ -	$ -		
Less MED (Qualified Medicare Beneficiaries)					
Less OEW payments associated with applicable visits			$ -		
Less services not included in PPS rate		$ -	$ -	-	
subtotal		$ -	$ -	-	#DIV/0!
Total Applicable Payments for Open Card Patients		-	-	-	#DIV/0!

		Patients	Visits	*Visits Per Patient*
1	Total			#DIV/0!
2	Less Dental Only			#DIV/0!
3	Less Mental Health Only			#DIV/0!
4	Less OB Only			#DIV/0!
5	Less Dental/Mental Health/OB Only			#DIV/0!
6	Less Full Year Open Card			#DIV/0!
7	Less Dental/Mental Health/OB Only Open Card			#DIV/0!
8	Less Partial Year Open Card Patients			#DIV/0!
	Less Cover All Kids			0
	Medicaid Managed Care For APM	-	-	#DIV/0!

PPS RATE		
Effective Date		

For OPCA to Fill Out	**Amount Paid**	**Valid Claims Total**	**Revenue Per Visit**
State Claims File - Open Card Data (Medical Only) for (INSERT Rate Setting Period)			

APCM Rate Methodology Worksheet



	Patients		Member Months	Ave NMs	Analysis: Patients Proportions	Analysis: NM Proportions
Total Patients				#DIV/0!		
Total Managed Care Patients			-		#DIV/0!	#DIV/0!
Total Full Year Open Card Patients			-		#DIV/0!	#DIV/0!
Less Dental Only Patients			-			#DIV/0!
Less Mental Health Only Patients			-			#DIV/0!
Less OB Only Patients			-			#DIV/0!
Less Combo Dental, MH, OB Only Patients			-			#DIV/0!
Total Non-Medical for Managed Care and Open Card			-			#DIV/0!
Used Other FQHC					#DIV/0!	#DIV/0!
Used Non FQHC					#DIV/0!	#DIV/0!
Used BOTH Other FQHC, Non FQHC					#DIV/0!	#DIV/0!
Care Providers for Managed Care and Open Card		0	0		#DIV/0!	#DIV/0!
Total Managed Care	-		-	#DIV/0!		
Less Dental Only Patients						
Less Mental Health Only Patients						
Less OB Only Patients						
Less Combo Dental, MH, OB Only Patients						
Total Non-Medical Patients for Managed Care	-		-			
Used Other FQHC		-	-			
Used Non FQHC		-	-			
Used BOTH Other FQHC, Non FQHC		-	-			
Total Patients Utilizing Other Primary Care Providers for Managed Care		-	-			
Applicable to Wrap Cap (Managed Care)	-		-			
Total Full Year Open Card				#DIV/0!		
Less Dental Only						
Less OB Only						
Less MH Only						
Less Combo Dental, MH, OB Only						
Full Year Open Card Total Non-Medical	-		-			
Used Other FQHC						
Used Non FQHC						
Used BOTH Other FQHC, Non FQHC						
Total Patients Utilizing Other Primary Care Providers for Open Card		-	-			
Full Year Open Card Member Months	-		-	#DIV/0!		
Total Partial Year Open Card				#DIV/0!		
Less Dental Only						
Less OB Only						
Less MH Only						
Less Combo Dental, MH, OB Only						
Partial Year Open Card Total Non-Medical		-	-			
Partial Year Open Card Member Months		-	-	#DIV/0!		
Managed Care Member Months	-		-	*Used for Proposed Wrap Cap*		
Full Year Open Card Member Months	-		-			
Partial Year Open Card Member Months		-	-			
Open Card Member Months	-		-	*Used for Open Card Rate*		

APCM Rate Methodology Worksheet

(Insert Health Center Name)		
Calculation of FQHC APM Rates		
(Insert Rate Setting Period)		
	Current MCO Only	APM
Total For Wrap Cap Calculation		$ -
Total Member Months	-	-
Proposed Wrap Cap		*#DIV/0!*
Trended for MEI to 7/1/2020 (1.8%)		***#DIV/0!***
Open Card Applicable Revenue		$ -
Open Card Applicable Member Months		-
Proposed Open Card Rate		#DIV/0!
Trended for MEI to 7/1/2020 (1.8%)		***#DIV/0!***

APCM Attribution Policy

- Re-attribution to other primary care providers
  - OHA monitors claims monthly, with a six-month look-back for “leakage” (primary care visit(s) to other providers)
  - OHA will remove an assigned member from a clinic (assignment end-date is one day prior to first “leakage” date within the look-back):
    - After one primary care visit to another FQHC/RHC/Tribal clinic
    - After two or more primary care visits to a non-FQHC/RHC/Tribal clinic
- Enrollment Change Report (ECR)
  - OHA documents all assignment (enrollment) changes and sends the ECR in a secure email prior to ending the assignment(s)
  - ECR indicates: Patient’s Recipient ID, Patient’s APCM start date and ‘new’ end date, Date-of-Service of each visit with a different primary care provider, and Leakage Type

APCM Attribution Policy

- Non-engaged patients
  - Following the clinic's Care STEPs report (e.g., Q2 2022, reported one month after the close of the quarter, in this case 7/31/2022), OHA does an eight-quarter look-back on each assigned member
  - OHA will remove an assigned member from a clinic if the member did not receive at least one Care STEP or visit within the eight quarters (assignment end-date is the last day of the previous quarter, e.g., 6/30/2022):
- Non-Engaged Closure Report (NECR)
  - OHA documents all non-engaged closures and sends the NECR in a secure email prior to ending the assignment(s)
  - NECR indicates: Patient's Recipient ID, Patient's APCM start date and 'new' end date

RESOURCES

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Resources

- FQHC AND RHC SERVICES (OARs)
- Federally Qualified Health Centers and Rural Health Clinics Program
  - APCM FAQs
  - Oregon Primary Care Association (OPCA)
- FFS fee schedule

Contact

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