NYS Managed Care Supplemental Payment Program for FQHCs
Policy Document

I. Authorizing Federal Legislation:

Effective January 1, 2001 the Benefits Improvement and Protection Act (BIPA) implemented a new Prospective Payment System (PPS) to determine all inclusive rates for Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC). These all-inclusive FQHC rates have been revised to reflect eMedNY fee-for-service (FFS) rate codes 4011 and 4012, further described below, in addition to the PPS rate code 4013. For the purposes of the supplemental payment program, the blended Medicaid rate refers to the weighted average of FFS rate codes 4011, 4012 and 4013.

Federal law 42 U.S.C. §1396a (bb)(5)(A) requires states to make supplemental payments to an FQHC or RHC pursuant to a contract between the FQHC and a Managed Care Organization (MCO) and/or Independent Practice Association (IPA) for the amount, if any, that the FQHCs blended Medicaid rate exceeds the amount of payments provided under the managed care contract for the services rendered by the FQHC.

II. Overview of Program:

To qualify for the program, the center must be an FQHC, RHC or an FQHC Look-a-like. For purposes of this document, FQHC shall refer to all three center types. FQHCs must apply annually to participate in the program via the Managed Care Visit and Revenue (MCVR) report.

In order to qualify to receive supplemental payments, the FQHC must have FQHC Medicaid fee-for-service rates in effect for the time period and site where services were provided to the MCO enrollee.

Each qualifying FQHCs supplemental payment rate is the difference between the FQHCs average per visit rate paid by MCO/IPAs and its specific blended Medicaid rate for each rate year. FQHCs bill eMedNY directly for the supplemental payment, for services provided to MCO enrollees that would otherwise qualify under Medicaid FFS rules for payment at one of the FQHCs three FFS rate codes – 4011, 4012 or 4013.

For managed care visits that are either unpaid or occur outside a contract between the FQHC and MCO/IPA, the State will reimburse FQHCs at the full FQHC rate under rate codes 4026, 4027 and 4028.

III. Determining the FQHC Specific Supplemental Payment Rate:

A. Submission of MCVR Report and Certification Form

The supplemental payment amount will vary by FQHC depending on its blended Medicaid rate and average managed care per visit rate with contracted MCOs/IPAs. The FQHC specific average managed care per visit rate will be determined based on data provided by the FQHCs on the MCVR report. FQHCs must list each contracted MCO (whether contracted directly or indirectly through an IPA contracted with an MCO), the number of visits each MCO/IPA paid the FQHC, and the average MCO/IPA payment per visit in the report. Beginning with the 2014 MCVR report, FQHCs will be required to submit unpaid and/or visits and revenue that occur outside a managed care contract as well; however, these visits are excluded from the calculation of the average managed care pre visit rate. The FQHCs CEO must sign an attestation as to the accuracy of the submitted report. Specific instructions for completion of the report are enclosed along with the report format (Attachment A), and Certification Form (Attachment B).

The amount of each FQHCs supplemental payment rate will be determined for each rate year, using the most current calendar year MCVR report available, to determine the average managed care rate and the blended Medicaid rate in effect for each FQHC. The FQHCs MCVR report submission as described above, will supply the data to calculate the average managed care payment. The MCVR report compares the calculated managed care average to the FQHCs blended Medicaid rate for the period, and identifies the net difference, if any, which would be the FQHCs supplemental payment for the period, assuming all information is approved. If an FQHC is reimbursed by MCOs at or above its blended Medicaid rate for the services provided, the supplemental payment for that FQHC would be zero for that period.

Beginning July 1, 2010 the Department of Health (DOH) implemented the Patient Centered Medical Home Program. FQHCs recognized by NYS and the National Committee for Quality Assurance (NCQA) as Physician Practice Connections-Patient Centered Medical Homes (PPC®-PCMH™) are eligible to receive enhanced payments from contracted managed care organizations.

Payments received related to the Medical Home program must be excluded from the managed care rate calculation as explained in the September 27, 2010 letter sent to all participating FQHCs. The MCVR report has been revised to accommodate Medical Home revenue. Medical Home revenue may be verified via the Medicaid Managed Care Operating Reports (MMCORs) submitted by all MCOs.

While the MCVR report is submitted on a calendar year basis, the supplemental payment rates are effective for the same time period as the PPS rate, which is October through September. If the FQHCs Medicaid PPS rate changes, the FQHC should notify DOH and the supplemental payment rate will be updated based upon the revised PPS rate for that period. Section IV illustrates the time periods and due dates for MCVR reports, PPS rates and supplemental rates.

B. Validation of Submitted Data by DOH

The information contained in MCVR reports may be validated by the Department of Health (DOH) using one or more of the following data sources: supplemental claims billed by FQHCs to NYS for the period, MCO encounter data showing paid FQHC visits, MCO Medicaid Managed Care Operating Reports (MMCORs) which list contracted FQHCs and paid visits, or any other data sources available to the Department.

The DOH may choose to accept the MCVR report as submitted, based on the attestation of data accuracy signed by the FQHCs CEO. The MCVR report and as well as other aspects of the program are subject to future audit by the Office of the Medicaid Inspector General (OMIG), NYS Office of the Attorney General or any other authorized body.

If however, the information on MCVR reports is so inadequate that a supplemental rate can not be established, the FQHC may be deemed ineligible for the time period in question.

IV. Timeframes for MCVR Report Submission

Supplemental/PPS Rate Period	MCVR Report Period	MCVR Submission Date
10/01/17 - 09/30/18	Calendar Year 2016	07/10/17
10/01/18 - 09/30/19	Calendar Year 2017	07/02/18
10/01/19 - 09/30/20	Calendar Year 2018	07/01/19

Supplemental rates will be updated after the FQHC rates are released that correspond to the supplemental period.

The above due dates are intended to provide FQHCs with adequate time to collect and report MCO payment data from the prior calendar year. FQHCs that do not submit the MCVR report as described in Section III.A. of this document, by the above submission dates will be ineligible to participate in the supplemental program for the corresponding supplemental rate period.

V. Criteria for Submitting Supplemental Payment Claims

FQHCs may submit supplemental claims to eMedNY for Medicaid, Health and Recovery Plan (HARP), HIV SNP, *Managed Long-Term Care (MLTC), *Fully Integrated Duals Advantage (FIDA), Essential Plans 3 & 4 (Aliessa population), *Medicaid Advantage (MA) or *Medicaid Advantage Plus (MAP) enrollee visits provided, for services that would otherwise qualify under Medicaid Fee-for-Service (FFS) for payment at the following rate codes:

- 4011 – FQHC Group Psychotherapy
- 4012 – FQHC Off-Site Services (Individual)
- 4013 – FQHC Individual Threshold Visit

Eligible supplemental claims must meet the following criteria:

- The FQHC must have an FQHC PPS Medicaid rate in effect for the date of service and site of service.
- The FQHC must be contracted with the enrollee's MCO either directly or through an IPA that contracts with the MCO for the service provided.
- Only one supplemental claim can be submitted for an enrollee for a given day. One supplemental claim is allowed per threshold visit.
- For audit purposes, the FQHC must have evidence of a paid claim from the MCO or IPA. Supplemental claims cannot be billed for visits for which the MCO denies payment.
- Under Medicaid FFS, the visit would have been billed under one of the three rate codes listed above.
- The enrollee's plan must be listed on the most recently submitted MCVR report.
- Visits NOT eligible for supplemental payment include the following:
    - Visits for which there is no managed care contract between the FQHC and the MCO.
    - Visits that are not covered or carved out of the managed care contract.
    - Child Health Plus enrollee visits are not eligible for Medicaid supplemental payment.
    - Visits for contracts between MCOs and individual providers, since under the Medicaid FFS system, such claims would not have been billed under one of the above rate codes.
    - Visits that under Medicaid FFS rules would not be eligible to be billed at one of the three FQHC rate codes listed above, i.e.: a Medicaid enrollee receives treatment during a threshold FQHC visit, which cannot be completed due to administrative or scheduling problems (e.g., follow-up laboratory testing or radiology procedures).
- FQHC covered services for Health and Recovery Plans
- *FQHC services included in the MA and MAP benefit packages including:
    - Dental
    - Podiatry
    - Occupational/Physical/Speech Therapies
    - Vision

- *FQHC services included in the MLTC benefit packages including:
  - Dental
  - Podiatry
  - Occupational/Physical/Speech Therapies
  - Vision
- *FQHC services previously included in the MLTC benefit package, folded into the FIDA benefit package including:
  - Dental
  - Podiatry
  - Occupational/Physical/Speech Therapies
  - Vision
- FQHC covered services related to the Aliessa population (formerly Medicaid):
  - Essential Plan 3 (100-138% FPL)
  - Essential Plan 4 (<100% FPL)

The OMIG or any other authorized body may conduct periodic audits to ensure that supplemental payments billed by the FQHCs are appropriate and meet the above criteria. For example, an audit may verify that each billed supplemental payment has a corresponding paid visit for the same day, services, and enrollee paid by the MCO to the FQHC. The corresponding visits may be confirmed using MCO encounter data. Supplemental payments not verified by the presence of a paid encounter record would be flagged, and the FQHC would need to provide evidence of the paid claim by the MCO to the FQHC for that day/service/enrollee.

VI. Billing Process for Supplemental Payments via eMedNY

Each FQHC must submit claims to eMedNY to receive the supplemental payment for each qualifying threshold visit they provide to a managed care enrollee. Supplemental claims should be submitted to eMedNY consistent with the general Medicaid claim process and rules. Claims must be filed within 90 days of the date of service. For claims that exceed the "over 90-day" status for claims processing, the FQHC must follow the current "over 90-day" claims processing procedures. Please note that the standard two-year limitation for submitting claims through eMedNY also applies to supplemental claims.

For more details about delayed claim submission including claims over two years old, refer to your provider manual's Information for All Providers - General Billing Section available at:
https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Billing.pdf.

FQHCs coming on the program or adding new sites must apply for participation and cannot begin submitting claims for the supplemental payment until supplemental payment rates have been loaded to the eMedNY system. FQHCs will be notified when the supplemental rates have been loaded.

Attachment A

Managed Care Visit and Revenue (MCVR) Report and Certification Form Instructions:

The MCVR Report must be completed in order to receive supplemental payments under the program. The report identifies each MCO that the FQHC directly contracts with, as well as any indirect contracts through an IPA, along with the number of visits and amount of MCO payments for Medicaid, Health and Recovery Plan (HARP), HIV SNP, Managed Long-Trem Care (MLTC), Fully Integrated Duals Advantage (FIDA), Essential Plans 3 & 4 (Aliessa population), Medicaid Advantage (MA) and/or Medicaid Advantage Plus (MAP) enrollees. Supplemental claims may only be submitted for enrollees covered by plans listed on the MCVR report.

The MCVR report also requests unpaid visit data for visits and/or revenue that occur outside a managed care contract; these visits are not used in the calculation of the Average Rate Per Visit.

The electronic and hard copy report must be completed and returned with a signed Certification form, also enclosed. The FQHC Name and Submission date must match on both the Excel Report and the Certification form. **Do not add any columns to the MCVR report.** Complete the **MCVR Report** for the **Report Year** as follows:

- Enter the **FQHC Name**
- **Report Submission Date**
  - Enter current date that the report is being submitted, in mm/dd/yy format.
  - The electronic report and the signed certification form must have the same date in order to verify that the certification form is for that particular MCVR report.
- Enter the **FQHC OPCERT**
- Enter the following information for contracts between the FQHC and an MCO or with an IPA that contracts with an MCO for Medicaid, Health and Recovery Plan (HARP), HIV SNP, Managed Long-Term Care (MLTC), Fully Integrated Duals Advantage (FIDA), Essential Plans 3 & 4, Medicaid (MA) and/or Medicaid Advantage Plus (MAP):
  - **MCO Name**
    - Enter the MCO name with which the FQHC has a direct managed care contract. MCOs include Prepaid Health Service Providers (PHSPs) and Health Maintenance Organizations (HMOs). Do not report any contractual arrangements other than those with an MCO or with and IPA that contracts with an MCO.
  - **IPA Name**
    - If the information being reported is through a contract directly with an MCO, leave this field blank.
    - If the information being reported is through an IPA contracted with the MCO, enter the IPAs name. Continue to report the visits and revenue associated with payments from the IPA for enrollees in the MCO reported under MCO Name.
    - **Note, visits and revenues through an IPA must be reported by the MCO. If an IPA contracts with multiple MCOs, the visits and revenues associated with each MCO must be reported separately.**

- **Number of Visits Paid by MCO/IPA (Column A)**
  - Enter the total number of visits paid by the MCO/IPA to the FQHC (Column A). In order to count as a visit for purposes of determining your managed care supplemental payment rate, the FQHC must have received payment from the MCO/IPA for that visit and included such amounts in Column B.
  - Only visits that would have been paid at one of the three FQHC rate codes under Medicaid fee-for-service should be reported.
  - Include only visits for Medicaid, Health and Recovery Plan (HARP), HIV SNP, Managed Long-Term Care (MLTC), Fully Integrated Duals Advantage (FIDA), Essential Plans 3 & 4, Medicaid Advantage (MA) and/or Medicaid Advantage Plus (MAP) enrollees, do not include visits for other managed care programs such as Child Health Plus as described in section V
  - If the MCO pays the FQHC for more than one visit per day, report all MCO payments for that day, but only one (threshold) visit.
- **Number of Unpaid Visits by MCO/IPA (Column A)**
  - Enter the total number of unpaid visits by the MCO/IPA to the FQHC (Column A).
  - Only visits that would have been paid at one of the three FQHC rate codes under Medicaid fee-for-service should be reported.
  - Include only visits for Medicaid, Health and Recovery Plan (HARP), HIV SNP, Managed Long-Term Care (MLTC), Fully Integrated Duals Advantage (FIDA), Essential Plans 3 & 4, Medicaid Advantage (MA) and/or Medicaid Advantage Plus (MAP) enrollees, do not include visits for other managed care programs such as Child Health Plus as described in section V.
  - If more than one visit per day, only report one (threshold) visit.
- **MCO/IPA Payments to FQHC (Column B)**
  - Enter the dollar amount of payment received by the FQHC from the MCO/IPA for the report calendar year (January – December) in Column B. This must include any capitation payments, as well as fee-for-service payments received by the FQHC from the MCO/IPA. Financial incentive payments received by the FQHC from the contracting MCO/IPAs are not included in the calculation of managed care supplemental payments under the Balanced Budget Act (BBA). The MCO/IPA payments must represent the baseline payment under the contract for services being provided, without regard to the effects of either positive or negative financial incentives that are linked to utilization outcomes or other reductions in patient costs. Do not include any bonus payments made to the FQHC in Column B. A **Bonus** is a financial incentive payment above and beyond the amount otherwise due to a provider under the terms of the contract and made to the provider according to terms and conditions outlined in the contract.
  - If the FQHC receives a global payment that includes services other than those that would have been billed at one of the three FQHC rate codes, (such as a global fee for prenatal/delivery/postpartum) only report the portion of MCO reimbursement related to the FQHC rate.
- **Withhold Adjustment (Column C)** (if applicable)
  - Enter any amount of withhold from the FQHC payments by the MCO/IPA, not reported in Column C. A **Withhold** is a portion of a baseline payment that would otherwise be due to a provider but is withheld under the payment terms of a

contract, which is partially or totally returned to the provider under agreed-to terms and conditions.

- **Medical Home Payments Received (Column D)** (if applicable)
  - If the FQHC has been recognized by NYS and NCQA as a Medical Home provider, enter the total amount of payments received from the MCO/IPA relating to the Medical Home program. These payments will be excluded from the rate calculation.
- **Adjusted MCO/IPA Payments to FQHC – (Column E)**
  - **NO INPUT NECESSARY,** this column will be automatically calculated by adding columns B and C.
- **Average Rate Per Visit – (Column F)**
  - **NO INPUT NECESSARY,** this will be automatically calculated by dividing Column E by Column A**.**
- **FFS Rates (Column A Lines 33-35)**
  - Enter the most current FQHC rates available (rate codes 4011, 4012, 4013) for your FQHC for the report calendar year in column A. The Prospective Payment System (PPS) rate (rate code 4013) is <u>less any amount for</u> **Patient-Centered Medical Home (PCMH) and Recruitment and Retention** (R&R) add-ons included in the rate. The Supplemental Payment Program does not reimburse for PCMH and R&R.
- **Visits – (Column B, Lines 33-35)**
  - Enter managed care visits associated with each rate code. These are managed care visits that would have been billed under these rate codes in Medicaid fee-for-service (FFS). The total number of visits will be automatically calculated and must equal the total visits reported in Column A, Line 22. If these number do not match, the MCVR will be deemed unacceptable which may jeopardize the FQHCs participation in the Supplemental Payment Program.
- **Weighted Revenue – (Column C, Line 33-35)**
  - **NO INPUT NECESSARY,** this will automatically be calculated by multiplying, by FFS rate code, the **FFS Rate** by **Visits.**
- **Weighted Average – (Column A, Line 36)**
  - **NO INPUT NECESSARY,** this will automatically be calculated by dividing the total **Weighted Revenue** by total **Visits** associated with each FQHC rate code.
- **Managed Care Average Rate– (Column F Line 32 & Column A Line 37,)**
  - **NO INPUT NECESSARY,** this will be automatically calculated as the **Total Adjusted MCO Payments to FQHC** for Medicaid, HIV SNP, HARP, MLTC, FIDA, Essential Plans 3 & 4, MA & MAP divided by the **Total Visits Paid by MCO/IPA** for Medicaid, HIV SNP, HARP, MLTC, FIDA, Essential Plans 3 & 4, MA & MAP.
- **Calculated Supplemental Payment Rate – (Column A, Line 38)**
  - **NO INPUT NECESSARY,** this will be automatically calculated by taking the difference between the **Weighted Average Rate** and the **Managed Care Average Rate Per Visit.**

While the supplemental payment rate is automatically calculated based on the information included on the report, it is NOT considered an approved supplemental amount. All data is subject to review and verification prior to any Supplemental Payment rate being finalized.

MCVR Report – Certification Form Instructions:

The Certification Form must be signed and dated by the Executive Director, CEO or CFO certifying that the information is accurate and complete.

> The FQHC Name must be entered and the Report Submission Date must be entered in mm/dd/yy format and must be the same date as the Report Submission Date on the Managed Care Visit and Revenue Report.

Failure to submit these forms by the due date will result in suspension of supplemental payments to the FQHC.

The completed electronic copy should be sent directly to the e-mail address below:

> bmcr@health.ny.gov

The completed hard copy should be sent directly to the address below:

> New York State Department of Health
> Office of Health Insurance Programs (OHIP)
> Division of Finance and Rate Setting
> Bureau of Managed Care Reimbursement
> One Commerce Plaza, room 1405
> Albany, New York 12210

Attachment B

Managed Care Supplemental Payment Program
Managed Care Visit and Revenue (MCVR) Report
Report Period: January – December

CERTIFICATION

FQHC Name: **Report Submission Date:**

______________________________________ ____________
mm/dd/yy

The undersigned hereby certifies that to the best of my informed knowledge and belief the statements made herein and the documents attached hereto are accurate, true and complete in all material aspects.

I understand that the New York State Department of Health is relying upon this certification as part of its review and approval process, and that should it be determined that this certification is materially false or incomplete or incorrect or includes incorrect, false or misleading information, appropriate enforcement action will be taken.

Signature: ____________________________________
Executive Director/CEO/CFO

Date: ____________________________________