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State Territory Name: NEW JERSEY

State Plan Amendment (SPA) #: 20-0015

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

September 15, 2023

Carole Johnson
Commissioner
Medical Assistance and Health Services
Department of Human Services
CN 12 Quakerbridge Plaza
Trenton, New Jersey 08625-0712

RE: Title XIX State Plan Amendment (SPA), Transmittal #20-0015

Dear Commissioner Johnson:

We have reviewed the proposed amendment to Attachment 4.19-B of your Medicaid State plan submitted under transmittal number 20-0015. This amendment was submitted in order to update the rates for Federally Qualified Health Centers (FQHC).

Based upon the information provided by New Jersey, we have approved the amendment with an effective date of October 1, 2020. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Division of Reimbursement Review (DRR) analyst Debi Benson at (312) 886-0360 or Deborah.Benson@cms.hhs.gov

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICIAD SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 20-0015

2. STATE: New Jersey

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2020

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

42 U.S. C. 1396a(a)(30)(A)

7. FEDERAL BUDGET IMPACT:
a. FFY 2021: $33.5M

b. FFY 2022: $37.3M

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19B Page 9(c) (1)-(13)
Attachment 4.19B Page 9(c) (14)
ATTACHMENT 4.19B PAGES 9(C)(1) - (9)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Same
New
ATTACHMENT 4.19B PAGES 9(C) (1)-(13)

10. SUBJECT OF AMENDMENT:
Federally Qualified Health Center (FQHC) Rates

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not required, pursuant to 7.4 of the Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: Carole Johnson

14. TITLE: Commissioner,
Department of Human Services

15. DATE SUBMITTED:
12/31/20

16. RETURN TO:

Jennifer Langer Jacobs, Assistant Commissioner
Division of Medical Assistance and Health Services
P.O. Box 712, Mail Code #26
Trenton, NJ 08625-0712

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: DECEMBER 31, 2020

18. DATE APPROVED:
September 15, 2023

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
OCTOBER 1, 2020

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
TODD MCMILLION

22. TITLE:
DIRECTOR, DIVISION OF REIMBURSEMENT REVIEW

23. REMARKS:

STATE AUTHORIZED PEN AND INK CHANGE
FOR BOXES 8 AND 9

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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I. General Provision in Establishing Payment Rates

a) The Payment Methodology for services performed on or after January 1, 2001 by Federally Qualified Health Centers (including FQHC look-alikes as approved by the Centers for Medicare and Medicaid Services) shall conform to:

   A. Section 702 of the Benefits Improvement and Protection Act (BIPA) legislation
   B. BIPA 2000 requirements for a Prospective Payment System (PPS).

b) The Alternative Payment Methodology for services performed by Federally Qualified Health Centers (including FQHC look-alikes as approved by the Centers for Medicare and Medicaid Services) will conform to:

   A. BIPA 2000 requirements for an alternative payment methodology (APM).
   B. The payment methodology determined under this methodology:

      1) Will result in a payment to the clinic of an amount which is at least equal to the PPS payment rate and satisfies the BIPA requirements.
      2) To qualify for an APM, FQHC must sign a written agreement with the State. FQHCs that have elected an alternative methodology have a single opportunity to request this alterative payment to the PPS methodology, which will be applied prospectively. Once an FQHC has opted out of an APM, it is no longer eligible to receive an APM.

II. Prospective Payment Rate System Methodology

Medicaid reimbursement for services provided by FQHCs or FQHCs look-alikes are reimbursed under either the prospective payment system (PPS) or an alternative payment methodology (APM) as selected by the Center.

a) Prospective Payment System – Existing FQHCs prior to October 1, 2000

   A. Effective on or after January 1, 2001 and for each year thereafter, Medicaid payments to the FQHCs will be based on PPS. The PPS shall be computed as follow:

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1) Add the final settled Medicaid costs of the FY 1999 and FY 2000 cost reports together and dividing the total by the number of final settled encounters provided to Medicaid beneficiaries during the FY 1999 and FY 2000 fiscal years.
2) The final settled Medicaid costs for the FY 1999 and FY 2000 cost reports will be adjusted as follow:
    a. FQHC administrative reimbursement shall be based on total allowable costs rather than allowable direct patient care costs, subject to an administrative cost limit of 30% of total allowable cost;

    b. FQHC reimbursement for productivity standards shall be based on those standards applied by Medicare for cost reporting purposes;
    c. the overall per encounter limit on FQHC Medicaid costs shall be increased from 110% of the Medicare limit to the Medicare limit plus $14.42; and
    d. allowable costs shall be determined by following Medicare principles of reasonable cost reimbursement.
3) The encounter rate may be adjusted for a change in scope of services (as defined in Section III); and
4) The encounter rate shall be adjusted for inflation using the percentage increase in the Medicare Economic Index (MEI) as defined in section 1842(i)(3) of the Social Security Act) applicable to primary care services (as defined in section 1842(i)(4)) furnished through December 31, 2000

b) Prospective Payment System – For New Providers (entities first qualifying as FQHCs after December 31, 2000) on or after January 1, 2001

A. Effective on or after January 1, 2001 and for each year thereafter, for new providers, the interim PPS encounter rates shall be the Statewide average PPS encounter rate.

B. The final PPS rate shall be computed as follow:

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1) Add the final settled Medicaid costs of the first year and the second year cost reports together and dividing the total by the number of final settled encounters provided to Medicaid beneficiaries during the first year and second year operations.
2) The final settled Medicaid costs for the first year and second year cost reports will be adjusted as follow:
   a. FQHC administrative reimbursement shall be based on total allowable costs rather than allowable direct patient care costs, subject to an administrative cost limit of 30% of total allowable cost;
   b. FQHC reimbursement for productivity standards shall be based on those standards applied by Medicare for cost reporting purposes;
   c. the overall per encounter limit on FQHC Medicaid costs shall be increased from 110% of the Medicare limit to the Medicare limit plus $14.42; and
   d. allowable costs shall be determined by following Medicare principles of reasonable cost reimbursement
3) The encounter rate may be adjusted for a change in scope of services (as defined in Section III); and
4) The encounter rate shall be adjusted for inflation using the percentage increase in the Medicare Economic Index (MEI) as defined in section 1842(i)(3) of the Social Security Act) applicable to primary care services (as defined in section 1842(i)(4)) furnished through December 31, 2000.

III. Change in Scope of Services

An FQHC may apply for an adjustment to its PPS and APM rate.

a) Adjustment For Changes To Scope of Services – on or After January 1, 2001

The PPS encounter payment rates may be adjusted for increases or decreases in the scope of services furnished by the clinic during that fiscal year. A change in scope of service is defined as a change in the type, intensity, duration and/or amount of services. A change in the cost of a service is not considered in and of itself a change

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in the scope of services. The state will implement scope of service changes as follows: (i) the addition of a new FQHC covered service that is not incorporated in the baseline PPS rate or a deletion of a FQHC covered service that is incorporated in the baseline PPS rate; (ii) a change in scope of service due to amended regulatory requirements or regulations; (iii) a change in the volume or amount of services as a result of of relocation, remodeling, opening a new clinic or closing an existing clinic site.; and/or (iv) a change in scope of service due to changes in technology and medical practice. The process for a change of scope adjustment is as follows: Providers must follow the Change in Scope of Service Application Requirements, as specified in State regulation. Providers must notify the Division of Medical Assistance and Health Services (DMAHS) in writing at least 60 days prior to the effective date of any changes and explain the reasons for the change.

A. Providers must submit documentation/schedules which substantiate the changes and the increase/decrease in services and costs (reasonable costs following the tests of reasonableness used in developing the baseline rates) related to these changes. The changes must be significant with substantial increases/decreases in costs, as defined in (3) below, and documentation must include data to support the calculation of an adjustment to the PPS rate.

It is recognized that the change of scope will be time-limited in most cases, due to start-up or phase-in costs associated with the change of scope. As the utilization level phases in, the need for the enhanced rate will diminish. The provider must address this in the change of scope request.

B. Providers may submit requests for scope of service changes either:
    1) once during a calendar year, by October 1, with an effective date of January 1 of the following year; or
    2) when the scope of service change(s) exceed(s) 2.5% of the allowable per encounter rate as determined for the fiscal period. The effective date shall be the implementation date of the change of scope that exceeds the 2.5% minimum threshold for a mid-year adjustment.

C. The provider will be notified by DMAHS of any adjustment to the rate by written notification following a review of the submitted documentations.

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D. The provider will be paid its PPS rate as initially determined by DMAHS, pending the determination as to whether an adjustment is necessary and if so, the amount of the adjustment. A payment recovery will be made for the period from the effective date of the adjustment to the date the revised rate is incorporated into the claims payment system.

b) Adjustment For Changes To Scope of Services under APM II – On or After October 1, 2020

Effective October 1, 2020 and thereafter, the encounter rate established under the APM II may be adjusted if an FQHC believes there has been a significant change in its scope of services. A change will not be considered significant unless it impacts the APM II base rate by 5% or more. The FQHC may submit a request for review of its APM rate. The request for a change in scope of service will be reviewed according to the process (as defined in Section III).

IV. Alternative Payment Methodology

a) Alternative Payment Methodology to PPS Encounter Rate – Existing Providers prior to October 1st 2000

A. Effective on or after January 1, 2001 and for each year thereafter, FQHCs in existence during the calculation of initial FY 1999 and FY 2000 PPS were offered an APM. The APM rate paid under this methodology must be agreed to by the individual FQHCs and will be at least equal to the PPS encounter rate.

B. Medicaid payments to the FQHC based on alternative methodology to PPS encounter shall be computed as follow:

1) The greater of the FY 1999 or FY 2000 final settled Medicaid cost report.

2) The final settled Medicaid costs for the FY 1999 and FY 2000 cost reports will be adjusted as follow:

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a. FQHC administrative reimbursement shall be based on total allowable costs rather than allowable direct patient care costs, subject to an administrative cost limit of 30% of total allowable cost;
b. FQHC reimbursement for productivity standards shall be based on those standards applied by Medicare for cost reporting purposes;
c. the overall per encounter limit on FQHC Medicaid costs shall be increased from 110% of the Medicare limit to the Medicare limit plus $14.42; and
d. allowable costs shall be determined by following Medicare principles of reasonable cost reimbursement;

The state will compare the amount paid under this APM to what would have been reimbursed under the PPS per visit encounter rate. This payment will be calculated annually, at the time the next year's MEI is published. If it is determined that the APM encounter rate is less than the PPS encounter rate, a one-time payment will be issued within 60 days of the date the MEI is published.

3) The alternative methodology encounter rate may be adjusted for a change in scope of services (as defined in Section III); and

4) The alternative methodology encounter rate shall be adjusted for inflation using the percentage increase in the MEI (as defined in section 1842(i)(3) of the Social Security Act) applicable to primary care services (as defined in section 1842(i)(4)) furnished through December 31, 2000.

b) Alternative Payment Methodology II for Deliveries and Ob/Gyn Surgeries – On or After July 11, 2008

A. Effective for service dates on or after July 11, 2008 for Medicaid/NJ FamilyCare fee-for-service beneficiaries, FQHCs that elect to be paid under this methodology shall receive reimbursement for deliveries and Ob/Gyn surgeries, at the higher of the Medicaid fee schedule rate for the particular code or the FQHC's PPS encounter rate. Reimbursement for surgical assistants will be at the Medicaid fee schedule rate for the particular code. In no event shall the

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payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of these services.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Amendment 4.19-B of the State Plan.

1) Antepartum and Postpartum encounters provided to Medicaid/NJ FamilyCare fee-for-service beneficiaries that are not included in the delivery code reimbursement, will be reimbursed to the FQHC at the PPS encounter rate.
2) Post-surgical encounters provided to the Medicaid/NJ FamilyCare fee-for-service beneficiaries that are not included in the Ob/Gyn surgical code reimbursement, will be reimbursed to the FQHC at the PPS encounter rate.
3) FQHCs shall receive reimbursement for deliveries and Ob/Gyn surgeries specified on the fiscal agent's website at www.njmmis.com

c) Alternative Payment Methodology III – On or After October 1, 2020

A. Effective on or after service dates on or after October 1, 2020, FQHCs providing services to Medicaid/NJ FamilyCare fee-for-service beneficiaries who elect to be paid under this methodology, shall be reimbursed with the Alternative Payment Methodology III (APM III).

1) The APM III will pay a rate equivalent to 100 percent of the Medicare FQHC base payment rate, adjusted for each FQHC based on the facility's location (referred to as FQHC geographic adjustment or FQHC GAF) plus $19.35 in accordance to Section 1834(o)(1)(A) of the Social Security Act.

2) FQHCs located in following counties are considered Northern Jersey (Bergen, Essex, Hudson, Hunterdon, Middlesex, Morris, Passaic,

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Somerset, Sussex, Union and Warren. FQHCs located in the following counties are considered Rest of Jersey (Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Monmouth, Ocean and Salem)

The FQHC APM III rate will be calculated as follows:

(Medicare Base PPS payment rate x FQHC GAF) + $19.35 = APM rate

3) The alternative methodology encounter rate shall be updated annually using the MEI (as defined in section 1842(i)(3) of the Social Security Act) and the FQHC geographic adjustment factor.
    1. DMAHS will compare the amount paid under this APM to what would have been reimbursed under the PPS per visit encounter rate. This payment will be calculated annually, at the time the next year's MEI is published. If it is determined that the APM encounter rate is less than the PPS encounter rate, a one-time payment will be issued within 60 days of the date the MEI is published.
4) The alternative methodology encounter rate may be adjusted for a change in scope of services (as defined in Section III)

B. New FQHC Providers on or after October 1,2020

1) A new provider will become eligible to be considered for the APM III established above in the first year if the new FQHC agrees to the APM III. The APM III will be effective on or after the new FQHC has a signed agreement with the State. For new providers the interim rate shall be the State-wide average FQHC encounter rate where the FQHC is located (Northern Region or the Rest of New Jersey).

2) If the new provider elected to change to the PPS encounter rate, DMAHS will compare the amount paid under this APM versus the amount to be paid under the PPS per visit encounter rate. This payment will be calculated based on the second year of cost report. If it is

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determined that the APM III encounter rate is less than the PPS encounter rate, a payment will be issued to the FQHC following the second year cost report calculations.

V. Managed Care Wraparound Payments:

a) FQHCs that provide services under a contract with a Medicaid managed care organizations (MCO) will receive quarterly wraparound payments for the costs of furnishing such services. The amount of wraparound payment shall equal the difference between the payments received from the MCO and the total payment the FQHC would receive under the PPS/APM methodology. In cases where an FQHC has a capitation payment contract with the MCO whereby it receives a PMPM, the amount payable to the FQHC shall be offset by the capitation payment, but in no case will the payment be less than the PPS/APM rate the FQHC would be entitled to receive on a per encounters basis. The FQHC shall report the aggregate of monthly capitation payments received covered for each quarterly wraparound submission. The quarterly wraparound payment submission effective July 1, 2021 are as follow:

A. FQHC may submit an initial wraparound request to DMAHS for wraparound reimbursement for the preceding quarter the first day after the quarter has ended and no later than 45 days after the end of the quarter (for example, FQHC may request first quarter initial wraparound payment on April 1st of each year and no later than May 15) The FQHC's Chief Financial Officer ("CFO") shall attest to the submission, that the claims are submitted in good faith and in accordance with regular business practices, and that they are believed and intended to represent payable claims. The initial wraparound request shall be reviewed to ensure that the initial request are payable encounters for initial wraparound payment. The initial wraparound payment shall equal to 100% of the FQHC's PPS rate or APM rate times the number of payable encounters minus the estimated MCO payments per encounter paid to the FQHC in the previous calendar year times the payable encounter. DMAHS shall issue initial wraparound payments within 30 days of receiving a clean and workable quarterly wraparound file and all required documentation.

B. FQHC shall submit an electronic support claim data Excel file for reconciliation no sooner than 90 days and no later than 120 days following the end of each quarter (for example, for the first quarter of each year, this submission is due

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no sooner than July 1 and no later than July 30). The electronic support claim data Excel file will be reviewed to ensure that encounters are payable and eligible for wraparound reconciliation payment. The wraparound reconciliation will be calculated at 100% of the FQHC's PPS rate or APM III rate times the number of payable and eligible encounters minus the MCO payments per encounter paid to the FQHC. Within 60 days of receipt of a wraparound reconciliation submission, a reconciliation shall be made between the initial wrap payment issued and the calculated wrap reconciliation payment. DMAHS will provide the FQHC with notice of the additional wrap payment due to the FQHC or the wrap overpayment due from the FQHC DMAHS shall issue any additional wrap payment due to the FQHC or any amount due shall be placed on hold against future payments to the FQHC.