Community Health Care
Association of New York State

FINANCIAL IMPACTS:
END OF THE PUBLIC HEALTH EMERGENCY AND OTHER CURRENT DEVELOPMENTS

CHCANYS 2023 Finance University

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CohnReznick LLP

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AGENDA

- Overview - End of the Public Health Emergency (PHE)
- Medicaid Redetermination
- Telehealth Reimbursement
  - Telehealth reimbursement rates
  - Impact on wraparound payment rates
- Strategies - Expanding Services to the Medicare Population
- CMS Innovation Center Payment Initiatives
- OIG Workplan
- Questions

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OVERVIEW – END OF THE PHE

- In 2020, President Trump declared a federal Public Health Emergency (PHE) due to the rapid, worldwide spread of the Corona Virus (COVID-19)
  - States followed - New York declared a state of emergency on March 7,2020
- As a result of this PHE, the federal and state governments enacted several funding initiatives and regulatory waivers and flexibilities to stimulate the economy and combat the COVID-19 pandemic
- The PHE changed the world as we knew it. Uncertainty looms in what the "new normal" will look like and what remains when the PHE ends

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HURRICANCE COVID-19

Timeline

2019……………….2020………………………….2021……….2022….2023…….2024

2019

Supplemental HRSA Funding

2022 and 2023

2020 COVID Pandemic

- All sides of a hurricane and tropical storm are dangerous, but **the strongest side of a hurricane is the right side based on the direction it is moving**. This is known as the dirty side.

- Meteorologists call this the "dirty side" because this is where the worst weather occurs.

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INITIATIVES DURING THE PHE

Numerous funding initiatives were instituted during the PHE to provide short-term relief to businesses and healthcare providers

Funding Source	Appropriation	Time Period
HRSA - COVID Supplemental Funding	$100,000,000	3/15/2020 - 3/14/2021
HRSA - CARES Act	$1,300,000,000	4/1/2020 - 3/31/2021
Expanding Capacity for COVID Testing	$583,000,000	5/1/2020 - 4/30/2021
American Rescue Plan Act - Operating	$6,100,000,000	4/1/2021 - 3/31/2023
American Rescue Plan Act - Capital	$950,000,000	9/1/2021 - 8/31/2024
HRSA COVID-Related Grants	***$9,033,000,000***	
FY22 Health Center Program Baseline	*$5,700,000,000*	*10/1/2021 - 9/30/2022*

Other COVID Funding Available:

COVID Rural Health Clinic Funding

Provider Relief Funds

Paycheck Protection Program (PPP) Loan

FCC Connected Cares

INITIATIVES DURING THE PHE

Waivers and flexibilities during COVID-19 Public Health Emergency (PHE) allowed providers to rapidly increase access to care

- Medicaid/Child Health Insurance Program (CHIP) continuous enrollment
- Change in Service Modalities and Location of Care:
  - Enhanced access and permitted social distancing by leveraging Telehealth: Audio only and Audio/Visual
  - Increased capacity and access: Home for both provider and patient
- Authorized Reimbursement – Audio only & Audio-Visual
- Expanded Workforce Flexibilities:
  - Licensure
  - Supervision requirements
  - Expansion of provider staff - specific services reimbursed when provided by pre-COVID non-billable staff

UNWINDING THE FEDERAL PHE

- One-time funding initiatives generally expire 2023-2024
- CMS waivers and flexibilities expired May 11, 2023
  - Unwinding continuous enrollment for Medicaid and Children's Health Insurance Program
    - States will return to normal eligibility and enrollment operations once PHE has officially ended
  - Certain FQHC Medicare flexibilities extended through December 31, 2024
  - Continuation of FQHC Medicaid telehealth flexibilities differ by state

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MEDICAID REDETERMINATION

- The Families First Coronavirus Response Act (FFCRA) mandated continuous Medicaid enrollment throughout the federal COVID-19 public health emergency (PHE) period for nearly all of those enrolled in Medicaid on or after the date of enactment on March 18, 2020, through the end of the month in which the PHE declaration ends.
- In exchange for meeting these and other provisions, the FFCRA temporarily increased the federal medical assistance percentage (FMAP) by 6.2 percentage points, which all states received.
- Estimated Enrollment Growth from February 2020 to March 2023*:
  - Nationwide = 23.3M
  - New York = 1.6M

* *Source: "Medicaid Enrollment Growth: Estimates by State and Eligibility Group Show Who may be at Risk as Continuous Enrollment Ends", March 2, 2023, Kaiser Family Foundation*

MEDICAID REDETERMINATION

- At the end of the PHE states will have 12 months to initiate redeterminations of Medicaid and CHIP eligibility for all enrollees and two additional months (14 months total) to complete all pending actions
- In December 2022 legislative update, Congress set an end to the continuous enrollment period on March 31, 2023 with a phase down through December 2023 (terminations are permitted to begin on April 1, 2023)
- Estimated Number of Enrollees Who Could Lose Medicaid When the Continuous Enrollment Provision Unwinds*:

	8% Disenroll	18% Disenroll	28% Disenroll
Nationwide	7.811,800	16,599,800	24,412,600
New York	671,200	1,422,400	2,085,900

* *Source: "How Many People Might Lose Medicaid When States Unwind Continuous Enrollment?", April 26, 2023, Kaiser Family Foundation*

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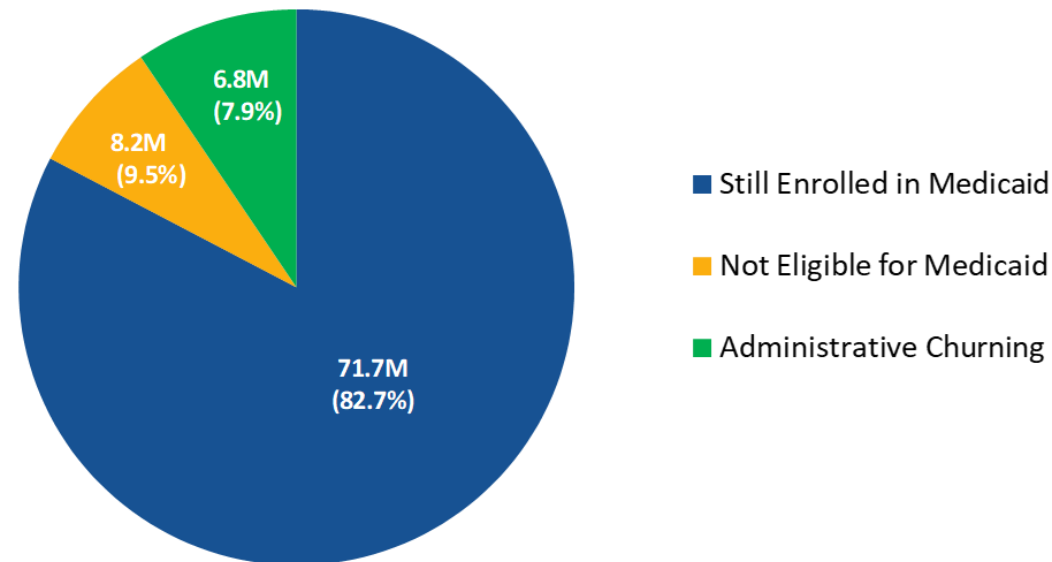
MEDICAID REDETERMINATION

- A little under half of the Medicaid enrollees are predicted to lose Medicaid coverage due to administrative "churn"

Figure 1. Predicted Eligibility, Ineligibility, and Administrative Churn Among Medicaid Enrollees at End of PHE



Source: Analysis of SIPP treating March 2015-Nov. 2016 as analogous to March 2020-Dec. 2021 PHE, among enrollees ever-enrolled in Medicaid during the 21-month period.

<u>Source</u>: "Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches", August 19, 2022, ASPE Office of Health Policy

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MEDICAID REDETERMINATION

Projecting the potential impact of Medicaid redetermination on your 2023/2024 operating budgets:

- Review your 2019 versus 2022 UDS reports:
  - Number of Medicaid managed care members
  - Mix (%) of Medicaid patients
- Review the visit utilization of patients by payer - 2019 versus 2022
- Project potential shift of patients and related visits from Medicaid to other payers (e.g., uninsured)
- Project the financial impact on patient revenues

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TELEHEALTH – NYS MEDICAID

Pre-COVID, NYS Medicaid billing regulations for FQHCs were very restrictive for telehealth services thereby disincentivizing FQHCs from providing telehealth

- Eligible service modalities
  - Live, interactive audio-visual communication ONLY
- Eligible FQHC billing rules
  - Originating site only - Offsite Visit Rate
  - Distant site, patient at home - Offsite Visit Rate
  - Distant site, patient at another Article 28 (including within FQHC network) - Threshold Visit Rate
- Wraparound billing
  - Visit billable under Threshold Visit Rate ONLY eligible for Wraparound billing

TELEHEALTH – NYS MEDICAID

Waivers and flexibilities during COVID-19 Public Health Emergency (PHE) allowed FQHCs to rapidly increase access to care

- Change in Service Modalities and Location of Care:
  - Enhanced access and permitted social distancing by leveraging Telehealth: Audio only and Audio/Visual
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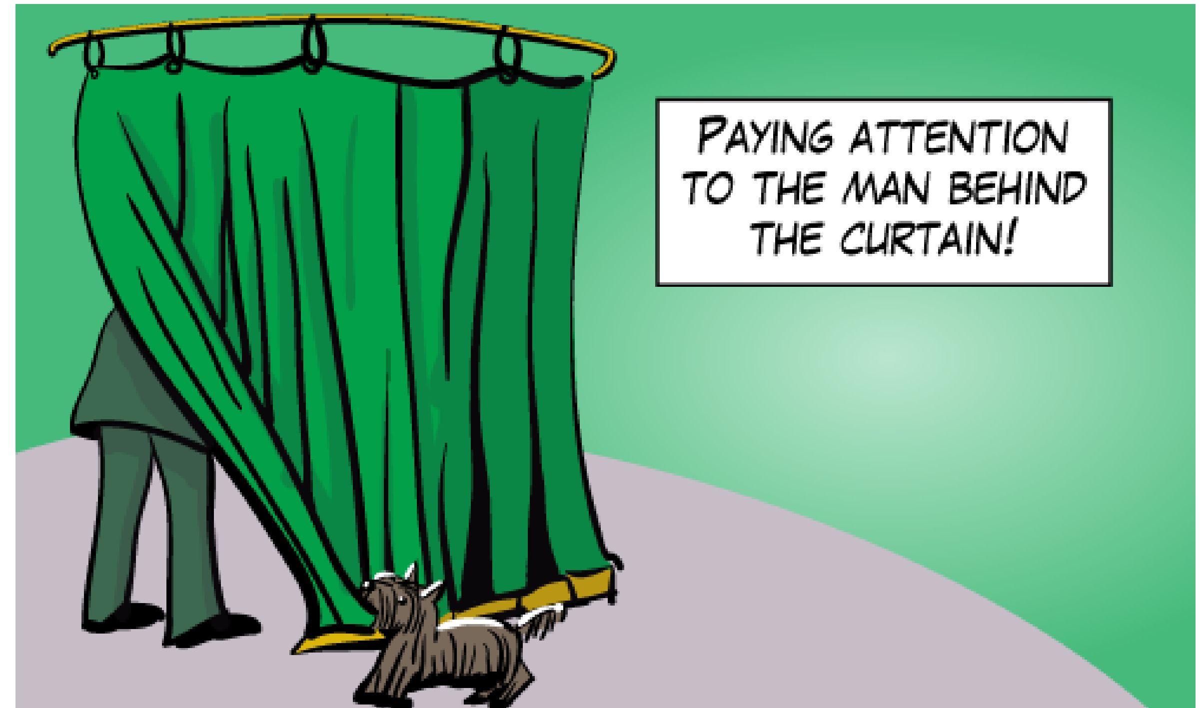
TELEHEALTH – NYS MEDICAID

- On Friday, June 25, 2021, the New York State Disaster Emergency declared by Executive Order 202 ended and all subsequent COVID disaster emergency Executive Orders also ended
- NYS Agencies (DOH, OMH, OASAS) issued extensions to the expired waivers and flexibilities
- In February 2023 (revised May 2023), DOH issued a special Medicaid Update (Volume 39, Number 3) containing comprehensive billing guidance for telehealth services post-PHE



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TELEHEALTH – NYS MEDICAID

- FY 2023 Enacted Budget
  - *Health care services delivered by means of telehealth shall be entitled to reimbursement … on the same basis, at the same rate, and to the same extent the equivalent services … are reimbursed when delivered in person:*
  - *Provided, however, that that health care services delivered by means of telehealth shall not require reimbursement to a telehealth provider for certain costs, including but not limited to facility fees or costs reimbursed through Ambulatory Patient Groups or other clinic reimbursement methodologies … if such costs were not incurred in the provision of telehealth services due to neither the originating site nor distant site occurring within a facility or other clinic setting*
  - *Notwithstanding the provisions of this subdivision, for services licensed, certified or otherwise authorized pursuant to Articles 16, 31 or 32, … such services provided by telehealth … shall be reimbursed at the applicable in person rates or fees established by law …*

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TELEHEALTH – NYS MEDICAID (ARTICLE 28)

- New York Medicaid Update, Special Edition, February 2023 (Updated)
  - *CHCANYS Position: Provide full reimbursement parity, regardless of patient or provider location, for in-person, audio-only and audio-visual telehealth*

On-Site Presence	FQHC Opting-In to APGs	FQHC Opting-Out of APGs
Only the provider is onsite.	Provider submits APG claim for services provided.	PPS Rate
Only the NYS Medicaid member is onsite.	Provider submits APG claim for services provided. Special billing If the off-site provider delivering service is not employed or contracted by the facility.	PPS Rate
Neither the provider nor the NYS Medicaid member is onsite.	Physician can bill for Professional Component only.	Off-site (4012) rate

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TELEHEALTH – NYS MEDICAID (ARTICLE 28)

- If a "new" FQHC PPS rate is calculated for situations in which both the patient and provider are at home, per the 2023 enacted budget the payment rate would be paid excluding the capital component of the FQHC Threshold PPS rate
  - Below is an example of how this "new" payment rate may compare to the current offsite visit rates

Rates effective 10/1/2021:	**Downstate**	**Upstate Urban**	**Upstate Rural**
Peer Group Ceilings:			
Administration	$49.63	$27.06	$31.23
Average - Medical/Dental/Therpies	$147.10	$98.64	$103.96
Total Operating Cost Component	$196.73	$125.70	$135.19
FQHC Offsite PPS Rates	$75.15	$67.13	$67.13
Variance	$121.58	$58.57	$68.06

NOTE: Above calculations assume the FQHC's operating component of the rate is at the peer group ceiling amount and excludes patient transportation and ancillaries.

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2021 MCVR RATE PARITY CALCULATOR

- Payment of the offsite visit rate for telehealth services provided when both the patient and provider at in their homes will affect the wraparound rate
- CHCANYS has developed an MCVR Rate Parity Calculator that evaluates the impact on future wraparound rates based on the MCVR if the home-home visits, paid at the offsite visit rate, were reimbursed at the FQHC Threshold visit rate

Health Center Name			
Submitted 2021 MCVR			
FFS Rates		**Visits**	**Weighted Revenue**
4011-Group Psych	$40.00	0	$0
4012-Individual Off-Site	$70.00	10,000	$700,000
4013-Threshold (PPS)	$150.00	90,000	**$13,500,000**
Weighted Average	$142.00	**100,000**	**$14,200,000**
Managed Care Average	$90.00		
Supplemental Rate	**$52.00**		

2021 MCVR with Payment Parity for Audio-only Visits			
FFS Rates		**Visits**	**Weighted Revenue**
4011-Group Psych	$40.00	0	$0
4012-Individual Off-Site	$70.00	0	$0
4013-Threshold (PPS)	$150.00	100,000	**$15,000,000**
Weighted Average	$150.00	**100,000**	**$15,000,000**
Managed Care Average	$90.00		
Supplemental Rate	**$60.00**		

2021 MCVR Impact of Audio-Only Rate Disparity	
Wrap Rate Reduction	($8.00)
Total Revenue Loss	($800,000)

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TELEHEALTH – NYS MEDICAID (ARTICLE 31/32)

- New York Medicaid Update, Special Edition, February 2023 (Updated)
  - *CHCANYS Position: Ensure consistency in payment across licensure types and payment models. How do FQHCs fit in?*

On-Site Presence	Article 31 Licensure	Article 32 Licensure
Only the provider is onsite.	Provider submits APG claim for services provided. No facility fee – no professional component.	Provider submits APG claim for services provided.
Only the NYS Medicaid member is onsite.	Provider submits APG claim for services provided. Special billing If the off-site provider delivering service is not employed or contracted by the facility.	Provider submits APG claim for services provided.
Neither the provider nor the NYS Medicaid member is onsite.	Physician can bill for Professional Component only. No bill for facility fee – no professional component.	Provider submits APG claim for services provided.

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TELEHEALTH – NYS MEDICAID (ARTICLE 31/32)

- New York Medicaid Update, Special Edition, February 2023 (Updated)
  - *How do FQHCs with Article 31 and 32 licenses get paid for telehealth services if they have opted-out of APGs?*

- Article 31 versus 28 licensure considerations:
  - Behavioral health service thresholds?
  - Integrated Outpatient Services (IOS) license ?
  - Delegated payment of the FQHC PPS rate to Medicaid managed care plans versus MCVRs and wraparound billing?
  - Telehealth reimbursement differences?

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TELEHEALTH - MEDICARE

- Extension of certain telehealth flexibilities - *Consolidated Appropriations Act of 2022*
  - FQHCs as a "distant site" provider - ability to bill under the Physician Fee Schedule will remain in effect through December 31, 2024
  - Payment of a facility fee if the patient is at home or other facility locations remain in effect through December 31, 2024
  - Payment for audio-only visits in effect through December 31, 2024
  - Requirement that virtual mental health visits conditioned on a patient having an in-person mental health visit in the prior 6 months postponed to December 31, 2024
  - Beginning on or after January 1, 2022, mental health services furnished via real-time telecommunication technology shall be reported and paid the same way as in-person visits

MEDICARE SERVICE EXPANSION

- FQHCs across the country are considering strategies to expand services provided to the elderly (Medicare) populations
- The successful strategy involves performing:
  - A market assessment of the unmet need for healthcare services in the community
  - A financial analysis of the profitability/sustainability of services
- The Medicare marketplace can be divided into 3 payer categories:
  - Medicare fee-for-service
  - Medicare Advantage
  - Medicare/Medicaid dual eligibles

MEDICARE SERVICE EXPANSION

Approach to Financial Analysis:

- Evaluate current revenue per visit/patient against PPS rates
- Compare against current cost per visit/patient (as calculated in Medicare cost report)
- Evaluate profit/loss per visit/patient by payer and plan
- Identify opportunities to increase revenue per visit/patient
  - Improve billing to capture full PPS rates
  - Improve Annual Well Visit rates
  - Bill supplemental Medicare wrap for Medicare Advantage plans
  - Add Care Coordination (CCM) component
  - 340B analysis
  - Value-Based Arrangements

ASSUMPTIONS

Cost per Visit

- Based on the FQHC Medicare Cost Report

Medicare Cost Report Period	Medical Cost per Visit	Mental Health Cost per Visit	Blended Cost per Visit
FY19 - 7/1/2018-6/30/2019	$ 151.47	$ 120.89	$ 148.10

Medicare Rates

- Medicare FQHC Rates are set nationally with a geographic adjustment factor (GAF) applied
- Enhanced Rates are available for Initial Preventive Exams (IPPE) and Annual Well Visits (AWV)
- Medicare requires 20% cost sharing by patients, allowing 80% to be billed to Medicare

National Medicare PPS Rate	$169.77
GAF	1.020
Esperanza Medicare PPS Rate	$173.17
Medicare Approved Amount (80%)	$138.54

Enhanced Medicare PPS Rate (IPPE/AWV)	$232.32
Medicare Approved Amount (80%)	$185.86

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CURRENT MEDICARE COLLECTIONS VS PPS RATE

- FQHCs have ability to bill for Wrap if Medicare Advantage plans pay less than PPS Rate
  - Medicare Advantage collections are approx. $30-60 less per visit than Medicare-billable PPS rate
  - In this example, the FQHC is not billing for wrap for Medicare Advantage plans

Payer Type	Visits	Unique Patients	Cash Collections*	Avg. Collections per Patient	Avg. Collections per Visit	Full Medicare PPS Rate	80% Billable to Medicare
Medicare FFS	1,326	571	$ 189,439.22	$ 331.77	$ 142.87	$173.17	$138.54
Medicare Advantage	1,580	337	$ 161,111.37	$ 478.08	$ 101.97		
Total Medicare	**2,906**	**908**	**$ 350,550.59**	**$ 386.07**	**$ 120.63**		
MCR/MDC Duals - FFS	1,257	332	$ 185,512.79	$ 558.77	$ 147.58	$173.17	$138.54
MCR/MCD Duals - Mcd Care	976	205	$ 111,126.64	$ 542.08	$ 113.86		
Total Medicaid/Care Duals	**2,233**	**537**	**$ 296,639.43**	**$ 552.40**	**$ 132.84**		
Total	**5,139**	**1,445**	**$ 647,190.02**	**$ 447.88**	**$ 125.94**		

MEDICARE/DUALS – NET REVENUE PER PATIENT

- In the example below, Current Collections per Visit vs. Cost per Visit are not sustaining services

Payer Type	# Visits	# Unique Patients	Cost per Visit (MCR)	Avg. Collections per Visit	Net Revenue per Visit
Medicare FFS	1,326	571	$ 148.10	$ 142.87	$ (5.23)
Medicare Advantage	1,580	337	$ 148.10	$ 101.97	$ (46.13)
MCR/MDC Duals - FFS	1,257	332	$ 148.10	$ 147.58	$ (0.52)
MCR/MCD Duals - Mgd Care	976	205	$ 148.10	$ 113.86	$ (34.24)
Total	**5,139**	**1,445**	**$ 148.10**	**$ 125.94**	$ (22.16)

Utilization	Avg. Collections per Patient	Cost per Patient	Revenue per Patient
2.32	$ 331.77	$ 343.92	$ (12.16)
4.69	$ 478.08	$ 694.36	$ (216.28)
3.79	$ 558.77	$ 560.73	$ (1.95)
4.76	$ 542.08	$ 705.10	$ (163.02)
3.89	**$ 447.88**	**$ 576.03**	$ (128.14)

	Other Revenue Opportunities				
Payer Type	Improve G-Codes	Expand AWV	Medicare Wrap Payments	Participate in Care Mgmt	340B Program
Medicare FFS	X	X		X	X
Medicare Advantage	X	X	X	X	X
MCR/MDC Duals - FFS	X	X		X	X
MCR/MCD Duals - Mgd Care		X			

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MEDICARE/DUALS – G CODES

G Codes

- FQHC Medicare claims are billed to Medicare based on G codes, or payment codes that represent a bundle of services that are typically furnished to a Medicare patient
- Medicare payment is made for the lesser of the Medicare PPS rate or FQHC G Code
- G codes set below the full FQHC Medicare PPS rate will result in reduced collections

CPT	Description	Esperanza G Code Fees	Medicare PPS Rate
G0438	PPPS, INITIAL VISIT	$ 281.08	$ 251.41
G0439	PPPS, SUBSEQ VISIT	$ 190.76	$ 251.41
G0442	ANNUAL ALCOHOL MISUSE SCREENING, 15 MINUTES	$ 19.51	$ 187.39
G0444	ANNUAL DEPRESSION SCREENING, 15 MINUTES	$ 19.14	$ 187.39
G0466	FQHC PPS NEW PT	$ 225.00	$ 251.41
G0467	FQHC PPS EST PT	$ 165.00	$ 187.39
G0468	FQHC IPPE AWV	$ 225.00	$ 251.41
G0469	FQHC PPS BH NEW PT	$ 225.00	$ 251.41
G0470	FQHC PPS BH EST PT	$ 165.00	$ 187.39

MEDICARE/DUALS – AWV CAPTURE

- FQHCs are reimbursed for Initial Preventive Physical Exams (IPPE) and Annual Wellness Visits (AWV) at a rate 34% greater than the FQHC Medicare base rate
- Evaluating the # of IPPE/AWV claims as a percentage of unique patients can shine the light on potentially scheduling or coding opportunities to enhance revenue

Payer Type	# Unique Patients	# with AWV	% Captured
Medicare FFS	653	163	25%
Medicare Advantage	337	70	21%
MCR/MDC Duals - FFS	0	0	0%
MCR/MCD Duals - Mgd Care	205	38	19%
Total	**1,195**	**271**	**23%**

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DUALS/MGD CARE – PLAN DETAIL

- A review of plan level detail may show that payment various significantly between plans
- Strategy consideration - partnering with plans with larger patient base and preferable payment arrangements

Plan Grouping	Visits	% of Total Volume	Collections*	Avg. Collections per Visit
Meridian Health Plan of Illinois	257	26%	$ 24,232	$ 94.29
Aetna Better Health of IL	263	27%	$ 34,016	$ 129.34
BCBS-IL - MMAI Community Option	212	22%	$ 28,314	$ 133.56
Humana	115	12%	$ 8,709	$ 75.73
WellCare	128	13%	$ 15,776	$ 123.25
Cigna HealthSpring	-	0%	$ 80	$ -
Community Care Alliance of Illinois	1	0%	$ -	$ -
Total Duals - Mgd Care Visits	**976**		**$ 111,127**	**$ 113.86**

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MEDICARE – ADDING CCM

- Chronic Care Management (CCM) reimbursement is available for eligible patients with multiple (2 or more) chronic conditions expected to last at least 12 months and place the patient at significant risk of death, acute exacerbation/decompensation or functional decline
- A qualifying face-to-face initiating visit is required within one year before CCM can be initiated
- CCM is open to Medicare FFS, Medicare Advantage, or Dual Eligible patients
- At least 20 minutes of care coordination services must be furnished in the calendar month to earn a monthly PMPM
- There are numerous software applications and vendors that can assist FQHCs with implementing and billing under the CCM programs

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MEDICARE– 340B ANALYSIS

- FQHCs should ensure that their 340B reporting provides the information to calculate net margins between payer sources
- Combining the average 340B net margin per patient with the average Medicare revenue patient and comparing to the average cost per patient will assist with evaluating how the expansion of services to the Medicare population would impact the financial performance of the Center

Medicare	Varying Capture Rates	
	Current	Sensitivity
340B Margin per Patient per Year	$1,128.73	$1,128.73
Capture Rate	30.31%	37.88%
Average Medicare Revenue per Patient	**$342.06**	**$427.58**

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PARTING THOUGHTS - MEDICARE

- Make sure to align the financial analysis with a detailed market assessment
- Average reimbursement rates for Medicare and Medicare duals should be evaluated
  - Comparisons should be made between the Fee-for-service and dual product lines
  - For Medicare Advantage and Dual plans, comparisons should be made between plans
- There may be other revenue cycle enhancement opportunities with Medicare
  - Evaluate Medicare G-code charges
  - Improve outreach to bring Medicare patients in for Annual Well Visits
  - Participation in the Medicare CCM program
- Adding 340B margins to overall reimbursement could add significant additional revenue per patient impacting the overall financial performance of the Medicare product line

CMMI PAYMENT INITIATIVES – ACO REACH

- The ACO Realizing Equity, Access, and Community Health (REACH) Model Goals:
  - Promotes Physician Leadership and Governance: At least 75% control of each ACO's governing body must be held by participating physicians
  - Requires at least two beneficiary advocates on the governing board
  - Protects Beneficiaries by enhancing the participant vetting, monitoring, and transparency
  - Stronger protections against inappropriate coding and risk score growth

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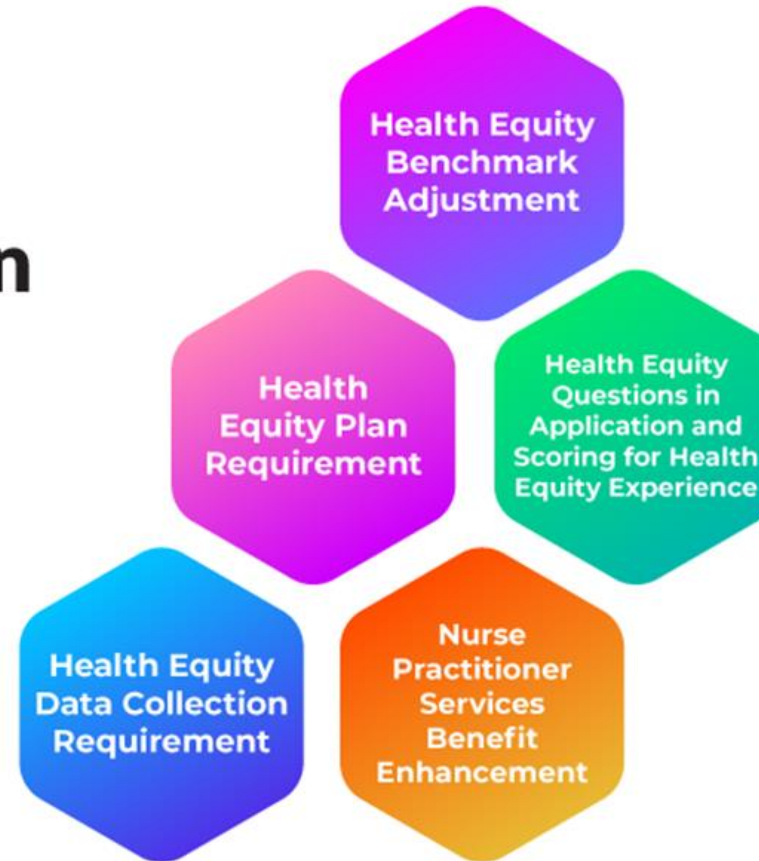
CMMI PAYMENT INITIATIVES – ACO REACH



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CMMI PAYMENT INITIATIVES – MCP MODEL

- On June 8, 2023, the Centers for Medicare & Medicaid Services (CMS) announced a new voluntary primary care model – the Making Care Primary (MCP) Model – that will be tested in eight states, including New York.
- Launching July 1, 2024, the 10.5-year model will improve care management and care coordination, equip primary care clinicians with tools to form partnerships with health care specialists, and leverage community-based connections to address patients' health needs as well as their health-related social needs (HRSNs) such as housing and nutrition.
- CMS is working with State Medicaid Agencies in the eight states to engage in full care transformation across payers, with plans to engage private payers in the coming months.
- CMS will begin accepting applications for the model in late summer 2023.

CMMI PAYMENT INITIATIVES – MCP MODEL

- The MCP Model will provide a pathway for primary care clinicians with varying levels of experience in value-based care to gradually adopt prospective, population-based payments while building infrastructure to improve behavioral health and specialty integration and drive equitable access to care
- The MCP care delivery approach communicates its vision for care delivery through three domains:
  - Care Management: participants will build their care management and chronic condition self-management support services, placing an emphasis on managing chronic diseases such as diabetes and hypertension, and reducing unnecessary emergency department (ED) use and total cost of care.
  - Care Integration: in alignment with CMS' Specialty Integration Strategy, participants will strengthen their connections with specialty care clinicians while using evidence-based behavioral health screening and evaluation to improve patient care and coordination.
  - Community Connection: participants will identify and address health-related social needs (HRSNs) and connect patients to community supports and services.

CMMI PAYMENT INITIATIVES – MCP MODEL

- MCP's three progressive tracks are designed to recognize participants' varying experience in value-based care—from under-resourced participants to those with existing advanced primary care experience in alternative payment models.
  - Track 1 -Building Infrastructure: Participants will begin to develop the foundation for implementing advanced primary care services. Payment for primary care will remain fee-for-service (FFS), while CMS provides additional financial support to help participants develop care transformation infrastructure and build advanced care delivery capabilities.
  - Track 2 - Implementing Advanced Primary Care: As participants progress to Track 2, they will build upon the Track 1 requirements by partnering with social service providers and specialists, implementing care management services, and systematically screening for behavioral health conditions. Payment for primary care will shift to a 50/50 blend of prospective, population-based payments and FFS payments. CMS will continue to provide additional financial support at a lower level than Track 1,
  - Track 3 - Optimizing Care and Partnerships: In Track 3, participants will expand upon the requirements of Tracks 1 and 2 by using quality improvement frameworks to optimize and improve workflows, address silos to improve care integration, develop social services and specialty care partnerships, and deepen connections to community resources. Payment for primary care will shift to fully prospective, population-based payment while CMS will continue to provide additional financial support, at a lower level than Track 2, to sustain care delivery activities while participants have the opportunity to earn greater financial rewards for improving patient health outcomes.

OIG WORKPLAN

Announced or Revised	Agency	Title	Component	Report Number(s)	Expected Issue Date (FY)
Revised	Health Resources and Services Administration	Audit of Health Resources and Services Administration's COVID-19 Supplemental Grant Funding for Health Centers	Office of Audit Services	W-00-21-59456	2023
Revised	Health Resources and Services Administration	Audit of CARES Act Provider Relief Funds – Payments to Health Care Providers That Applied for General Distribution Under Phases 1,2, and 3	Office of Audit Services	W-00-21-35873; W-00-22-35873	2023

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CONTACT

Peter R. Epp, CPA

Partner
Community Health Centers
Practice Leader

646-254-7411 Peter.Epp@CohnReznick.com

linkedin.com/in/peterrepp13/

Community Health Care Association of New York State