

**WEST VIRGINIA CHILDREN'S HEALTH  
INSURANCE PROGRAM**  
**FQHC/RHC PROSPECTIVE PAYMENT SYSTEM (PPS)**

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**SYSTEM OVERVIEW AND POLICIES**

**NOVEMBER 30, 2011**



# WEST VIRGINIA CHILDREN'S HEALTH INSURANCE PROGRAM FQHC/RHC PROSPECTIVE PAYMENT SYSTEM (PPS) SYSTEM OVERVIEW AND POLICIES (DRAFT)

## Introduction

In 2009, Congress promulgated the Children's Health Insurance Program Reauthorization Act (CHIPRA) reauthorizing and expanding the CHIP program<sup>1</sup>. Within this legislation is a requirement that effective for services provided on or after October 1, 2009, state CHIP programs must reimburse Federally Qualified Health Centers (FQHCs) and rural health clinics (RHCs) in accordance with the requirements imposed on Medicaid programs under section 1902 (bb) of the Social Security Act. Section 1902 (bb) of the Social Security Act mandated that state Medicaid programs provide reimbursement to FQHCs and RHCs under a Prospective Payment System (PPS) with a cost-based payment per encounter (PPS rate). If a PPS was not implemented, states had the option of implementing an alternative payment methodology (APM), as long as the APM did not pay less than what would be paid under a PPS. In accordance with the requirements of the CHIPRA legislation, the WVCHIP has developed a PPS methodology for reimbursement of FQHCs and RHCs. CMS guidance on the CHIPRA legislation offered the following options that a state CHIP programs may adopt in order to comply with the legislation: 1) adopt Medicaid PPS rates; 2) develop separate CHIP rates; or 3) develop an alternative payment methodology (APM)<sup>2</sup>. After convening a workgroup and evaluating the available options, the WVCHIP has determined that CHIP PPS rates will be implemented. This report outlines the policies of the PPS.

## 1. PPS Rate Setting

### 1.1 Cost Report Collection and Review

The Social Security Act specifies that the PPS payment, or PPS rate, must be based on actual cost. For the Medicaid program, the basis of Medicaid PPS rates is provider costs reflected on FQHC and RHC cost reports for provider fiscal years 1999 and 2000. The CHIPRA legislation does not specify a particular base time frame; thus, CHIP programs have the flexibility to select the base year period. The workgroup has selected 2006 and 2007 as the PPS base periods, and costs have been collected via the Medicare cost reports for those years (cost reports ending during calendar years 2006 and 2007). Using the option selected by WVCHIP (separate CHIP PPS rates), CMS indicated that states may utilize the Medicare cost report to collect the necessary cost and visit data, and Medicare reasonable cost principles must be applied to the development of CHIP PPS rates. We believe that the Medicare cost report is the best option available for collecting cost and visit data necessary to develop PPS rates. The Medicare cost report collects costs in a standardized format, is a cost reporting mechanism that is familiar to

<sup>1</sup> Public Law 111-3, Section 503, Feb. 4, 2009

<sup>2</sup> Centers for Medicare and Medicaid Services, State Health Official (SHO) Letter #10-004, February 4, 2010



providers, and contains detailed instructions to which providers must adhere in preparing the cost report in accordance with Medicare reasonable cost requirements. Utilizing the Medicare cost report eliminates the need to develop a CHIP-specific cost report, which would likely be a tedious process and would collect much the same information as the existing Medicare cost report.

On October 22, 2010, all FQHCs and RHCs were asked to submit the necessary cost reports. Because providers have varying fiscal years, some of which are not a calendar-year period, the cost reports collected were those ending during calendar years 2006 and 2007. According to CMS guidance provided to states in the form of questions and answers relative to the implementation of Medicaid PPS<sup>3</sup>, for providers who qualify as an FQHC or RHC in the second of the two PPS base years, the cost report relating to the second year will be the only cost report used to establish the PPS rate. Therefore, to be consistent with the Medicaid PPS statute, for providers who qualified as an FQHC or RHC in 2007, the 2007 cost report is the sole basis for the PPS rate. For new providers who qualify after 2007, a different methodology will be used. Likewise, for providers who have not submitted the requested cost reports, a different methodology will be required, and these issues are discussed in section 1.3 below.

The collected cost reports were reviewed under a standardized review process focused on identifying allowable costs for the CHIP program. These desk reviews were performed on the Medicare cost report information. These reviews are not audits but are analytical reviews of submitted cost information to assess the reasonableness of reported costs and to identify if any adjustments to costs are warranted. Such adjustments may include removing non-allowable costs, if not already offset by the provider, or adding back costs that were offset for the Medicare program (e.g. dental costs). The desk reviews were performed using a standardized desk review program that was approved by the agency. Exhibit 1 contains the desk review procedures.

Most providers were notified of their PPS rates on May 31, 2011, although there were a few providers who did not submit their cost reports in a timely fashion who were notified between June and August 2011. The PPS rates were communicated in the form of a letter, which provided for an appeal period of 30 days in which the provider could respond to the PPS rate determination.

## 1.2 Baseline PPS Rate Calculation

The PPS rate is a cost-per-visit rate, calculated by dividing allowable costs by visits. CMS guidance specified that the PPS rate calculation should reflect CHIP costs divided by CHIP visits, and states may use the Medicare cost report to identify these factors<sup>4</sup>. The Medicare cost report does not have the functionality to isolate CHIP costs or CHIP visits, and it would likely be difficult for providers to identify the portion of their costs specifically relating to CHIP services. One way to satisfy this requirement is to utilize a cost report and rate setting convention known

<sup>3</sup> CMS, Questions and Answers (Qs and As) on Medicaid PPS, October 2001

<sup>4</sup> CMS, State Health Official (SHO) Letter #10-004, February 4, 2010



as cost apportionment, in which total costs are apportioned to the program using a statistical basis such as beds, patient days, or visits. A valid statistical basis for this purpose is CHIP visits, the apportionment being determined by the relationship between total visits and CHIP visits. CHIP costs would be calculated by multiplying total costs by this relationship (CHIP visits/total visits x total costs = CHIP costs). As an example, Table 1.2.1 below illustrates this calculation:

**Table 1.2.1**

Total Visits	5,000	Total Costs	\$800,000
CHIP Visits	<u>1,000</u>	CHIP %	<u>20%</u>
CHIP %	20%	CHIP Costs	\$160,000

This assumes the availability of an accurate CHIP visit count. CHIP visits are reported by FQHCs on UDS reports (although the UDS reports do not align with the cost reporting period if other than a calendar year), and RHCs do not report CHIP visits on any documentation currently collected, although we presume CHIP visits could be determined from claims data. CHIP costs would then be divided by CHIP visits to determine the CHIP cost per visit. However, this mathematical result of this exercise is a cost per visit amount that is equal to the total cost per visit amount; therefore, the cost per visit derived by dividing total costs by total visits is an appropriate proxy for a CHIP cost per visit. This is also the approach used by Medicare in determining the per-visit amount for Medicare services. Using the above example, Table 1.2.2 below illustrates this calculation:

**Table 1.2.2**

Total Costs	\$800,000	CHIP Costs	\$160,000
Total Visits	<u>5,000</u>	CHIP Visits	<u>1,000</u>
Total Cost per Visit	\$160.00	CHIP Cost per Visit	\$160.00

After the cost per visit is determined for each of the PPS base years, the baseline PPS rate is calculated by averaging or combining the two years. CMS guidance relating to the Medicaid PPS instructed states to use one of two “reasonable” averaging methods for calculating the baseline PPS rate. The first method is to calculate two separate cost-per-visit amounts for each of the base years and average the two amounts. The second methodology consists of combining the costs for the two base years and the visits for the two base years and dividing the combined costs by the combined visits. The two methodologies will result in approximately the same baseline PPS rate; however, minor variations may occur because the second methodology is essentially a weighted average in which the rate is weighted toward the cost-per-visit of the base year with higher number of visits. The WVCHIP PPS rate is calculated using the first option (average of the two cost-per-visit amounts). As noted previously, for providers who qualify as a FQHC or RHC in calendar-year 2007, the 2007 cost report will be the sole basis for the PPS rate.

Once the baseline PPS rate is established, the PPS rate will be inflated in subsequent periods. The BIPA legislation requires the use of the Medicare Economic Index (MEI) applicable to primary care services. The MEI is published annually in the Medicare physician fee schedule final rule. In recent years, the MEI has declined as shown in the table below.



Table 1.2.3

<u>2006 MEI</u>	<u>2007 MEI</u>	<u>2008 MEI</u>	<u>2009 MEI</u>	<u>2010 MEI</u>	<u>2011 MEI</u>
2.8%	2.1%	1.8%	1.6%	1.2%	0.4%

Providers may assert that inflating the PPS rate by the MEI does not correspond to rising costs, which may be true given the declining MEI. However, the MEI is required by the PPS statute, and thus it does not appear that other inflationary indices should be used.

### **1.3 PPS Rates for New Providers and Non-Responsive Existing Providers**

For new providers who qualify as an FQHC or RHC after the base years (2006 and 2007), PPS rates will be established using a different methodology than outlined above. The PPS statute specified that PPS rates for new providers should be based on the rates of other providers located in the “same or adjacent area with a similar case load”, and if there are no nearby providers with a similar case load, cost data may be used. We believe states have flexibility in implementing the provisions of the statute as it relates to new providers because the PPS statute lacks specificity. The legislation does not define “same or adjacent area” or “similar caseload”. The vagueness of this terminology leaves these definitions open to interpretation and the program at risk of disputes with providers if the resulting rates do not approximate the provider’s actual costs (at least in an initial period) or if the provider feels the other providers’ rates are dissimilar. The legislation also does not define how other provider rates should be applied, e.g. should the state select one provider who is close in proximity and who has a similar caseload, or should the state select multiple other providers, if such exist, and calculate a blend (average, median, etc.) of the other provider’s rates. Additionally, the legislation is not clear as to whether the state would need to monitor the nearby and caseload-similar providers to ensure that changes to those provider’s PPS rates, such as a change in scope of service, are reflected in the new provider’s rates because the new provider’s rate is essentially tied to the other providers.

Due to the above factors, PPS rates for new providers will be calculated based on reasonable costs, as a cost-based methodology is also permitted under the PPS statute. Multiple state Medicaid programs utilize cost reports rather than other providers’ rates. Use of the Medicare cost report is a reasonable approach and achieves consistency with the methodology for existing providers. Consideration was given regarding whether to use one year or two years as the basis for the final PPS rate for new providers. Utilizing two years is consistent with the two PPS base periods for existing providers. However, it may difficult for new providers if they are required to wait for two full cost reporting periods until the assignment of a final PPS rate.

The WVCHIP has implemented a methodology similar to Medicare (and many state Medicaid programs) whereby an interim PPS rate is established for payment purposes until historical cost report data can be reviewed to establish a final PPS rate. Methodologies for establishing the interim rate include a utilizing a projected cost report (containing projected or budgeted costs and visits), a cost report reflecting actual cost and visits for a partial year period, the Medicare per-visit rate, or nearby providers with a similar caseload (although likely not the preferred option for



a final PPS rate, this may be feasible for interim rates). For Medicare purposes, providers are required to submit a budgeted cost report, which is used by Medicare to establish the interim Medicare per-visit rate. The Medicare budgeted cost report was determined to be the best option for establishing interim PPS rates because it is typically a readily available data source that is prepared by providers for Medicare rate purposes.

For new FQHC and RHC providers, interim PPS rates will be assigned until a final PPS rate can be calculated based on cost report information. The initial interim PPS rate will be a statewide average PPS rate of all existing providers within the same rate group, excluding the lowest and highest rate. For purposes of the average PPS rate, existing providers will be grouped into the following rate groups: FQHCs, freestanding RHCs, and provider-based RHCs. For each of the three rate groups, an average PPS rate will be established based on the PPS rates of existing providers in the group, excluding the lowest and highest rate. A new provider will receive the statewide average for that group. For example, a new freestanding RHC will receive the average PPS rate of all existing freestanding RHCs. Providers will be notified by the WVCHIP of their interim PPS rate.

A secondary interim PPS rate may be established based on the provider's first full year actual cost report. The purpose of the secondary interim PPS rate is to replace the initial interim PPS rate based on the statewide average with an interim PPS rate based on actual costs. The secondary interim PPS rate will be effective until the second full year cost report is available and a final PPS rate can be computed in accordance with the final PPS rate methodology in this manual.

Final PPS rates for existing providers in operation at the time of the implementation of this PPS were based on Medicare cost reports for provider fiscal years ending during calendar year 2006 and 2007. Calendar years 2006 and 2007 are referred to as the PPS base years. For providers who qualify as an FQHC or RHC in the second of the two PPS base years (2007), the cost report for the second year is the only cost report used to establish the PPS rate. PPS rates were calculated after the submitted cost reports were desk reviewed and any adjustments identified for non-allowable costs, or for the inclusion of allowable costs for the CHIP program that are non-allowable for the Medicare program. The PPS rates were calculated as the average cost-per-visit of the desk reviewed and adjusted base year cost reports. The WVCHIP PPS rate development does not take into account Medicare rate caps or Medicare productivity screens.

For new providers qualifying as an FQHC or RHC after the PPS base years, final PPS rates will be based on the Medicare cost reports for the center or clinic's first two complete fiscal years of operations. For example, if a clinic becomes a RHC on October 1, 2011 and has a December 31 fiscal year end, the final PPS rate will be established using the provider's FYE 12/31/2012 (first full year) and 12/31/2013 (second full year) Medicare cost reports. Providers must submit these cost reports in accordance with the cost report submission requirements noted in this manual.



There were a few providers who did not submit the requested cost report information. For these providers, a PPS rate was assigned based on the methodology for interim PPS rates utilizing the statewide average PPS rate for the appropriate provider group.

## **2. PPS Rate Development**

### **2.1 Single PPS Rate or Multiple PPS Rates**

Under a single PPS rate structure, all reimbursable visits are paid under one global PPS rate that provides reimbursement for all covered services (with the exception of any services excluded from the rate by design). Administratively, a single PPS rate structure is advantageous over a multiple rate structure due to the relative ease of developing and maintaining one set of PPS rates. A single rate structure also minimizes downstream impacts and complexity of other system areas, such as adjustments to PPS rates due to changes in the scope of services and managed care supplemental payments.

Under a multiple rate structure, separate PPS rates are developed for specific service categories, such as medical services or dental services. Given the common data source for the PPS rates (Medicare cost report), the initial calculation of multiple PPS rates is not problematic. However, from an administrative perspective, ongoing maintenance of multiple PPS rates can be potentially burdensome with exponential additional effort involved in annual inflationary updates of the rates, adjustments due to changes in the scope of service, and managed care supplemental payments. For a change in scope of service, an evaluation of the change will be necessary to determine which PPS rate it impacts (i.e. the change in scope may impact only one of the PPS rates or it may impact all of the PPS rates). Managed care supplemental payments also become more complex because of the need to separately identify the types of services and align the services with the appropriate PPS rates. See subsequent sections for information regarding changes in the scope of services and managed care supplemental payments.

Despite the obstacles to implementation, maintenance, and ancillary impacts, separate PPS rates may provide more focused reimbursement toward the targeted areas, e.g. the development of dental PPS rate incorporates dental costs and does not include costs of other types of services. Furthermore, there may be programmatic objectives that make multiple PPS rates the preferred option. For example, separate PPS rates for dental services may be desired to incentivize the provision of dental services and ensure access to these services for CHIP members (assuming dental PPS rates are higher than the global PPS rate).

After consideration of these factors, the WVCHIP has determined that a single PPS rate is the appropriate methodology. Exhibit 2 contains the baseline PPS rates for all FQHCs and RHCs.

### **2.2 PPS Rate Included/Excluded Services**



An encounter-based payment typically includes reimbursement for the professional face-to-face service and any related services or supplies, including services incident to the professional service. In Medicare policy, these “incident to” services are defined as services and supplies that are an incidental but integral part of the service, commonly furnished in a physician’s office, commonly rendered without charge or included in the bill, furnished under the supervision of the health care professional, and rendered by a staff member of the center or clinic<sup>5</sup>. Other services that may be related to a professional face-to-face service include laboratory services, radiology services, and prescription drugs, and medical supplies and equipment.

A strict interpretation of the PPS statute is that all covered FQHC/RHC services must be factored into the PPS rate, including such services as laboratory and radiology services and services that are considered “incident to” the practitioner’s face-to-face service. Some states have applied this interpretation and have bundled into the PPS rate all services that are covered under the state plan. Other states have removed certain services from the PPS rate and provide separate reimbursement for these services (usually through a fee schedule), the most common examples being laboratory services, radiology services, and prescription drugs<sup>6</sup>. Some states allow their FQHC/RHC providers to elect what services are included or excluded from their PPS rate. It appears that CMS has been flexible in allowing states to implement widely divergent PPS methodologies.

The WVCHIP PPS rates will exclude certain types of non-encounter services from the computation of the PPS rates and will provide reimbursement for these services separately. The excluded services are laboratory services, radiology services, and prescription drugs. For pharmacies without an in-house pharmacy, the costs of dispensing physicians are included in the PPS rates.

Services that are provided in a non-FQHC/RHC setting are considered non-FQHC/RHC services and are not included in the PPS rate. Examples include services provided by clinic practitioners to clinic patients in an inpatient hospital or outpatient hospital setting. There are a few states that have included these services in the PPS rates; however, it is consistent with Medicare and many other states to exclude these services. While excluded from the PPS rate, if these services are covered services, they may be billed and paid outside of the PPS rate. Additionally, because under Medicare cost reporting guidelines providers are not to include on the cost report such services rendered in a non-FQHC/RHC setting, these costs are not included in the PPS rate development based on Medicare cost reports.

Medicare policy does recognize as FQHC/RHC services those services provided to a clinic patient residing in a nursing facility or skilled nursing facility, and services provided in a patient’s home (in an area in which there is a shortage of home health agencies). Therefore, PPS rate reimbursement is available for services provided to patients who are homebound or in a nursing facility or skilled nursing facility and are unable to present at the center or clinic.

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<sup>5</sup> 42 C.F.R. 405.2413

<sup>6</sup> National Association of Community Health Centers (NACHC), State Policy Report #30, September 2009



Approved FQHC/RHC service settings for PPS rate reimbursement, represented by the place of service code, are listed below. Providers must bill the appropriate place of service code on the claim.

Place of Service Code	Place of Service Description
03	School (school-based location must be FQHC/RHC certified)
11	Office
12	Home
31	Skilled Nursing Facility
32	Nursing Facility
50	Federally Qualified Health Center
72	Rural Health Clinic

### 2.3 Productivity Standards

The Medicare cost report utilizes productivity standards in the computation of practitioner visits. For example, for physicians, Medicare applies a productivity standard of 4,200 visits for 1 full-time equivalent (FTE). If a physician of 1 FTE provides less than 4,200 visits, the cost report formula utilizes the productivity standard rather than the practitioner’s actual visits. Because practitioner visits are the denominator of the PPS rate calculation, use of productivity standards rather than actual visits can have a significant impact on the PPS rate. The productivity standard has been used by Medicare for many years, and in developing Medicaid PPS methodologies, many states adopted similar productivity standards. Productivity standards are viewed as a means of promoting efficiency, guarding against artificially low visits, and providing a common baseline for all providers. However, the result is a reimbursement structure with lower PPS rates than a system that does not utilize productivity standards. Section 1902 (bb) of the Social Security Act, and subsequent CMS guidance on Medicaid PPS, contain no discussion of productivity standards. In fact, based on a strict interpretation of the PPS statute, one could conclude that productivity standards are not appropriate. Additionally, because productivity standards can serve to push down PPS rates, providers may oppose their use in the development of PPS rates.

An issue brief published by the National Association of Community Health Centers (NACHC) noted that courts in Connecticut and Maryland have struck down those states’ use of productivity standards. This publication contains the following information regarding the history of the productivity standard:<sup>7</sup>

HRSA had used the 4,200 visit standard based on productivity data it had collected in 1978 on Rural Health Clinics (“RHCs”). The Health Care Financing Administration (“HCFA”) then used this productivity standard when it set a Medicare reimbursement rate for RHCs in 1982 and extended it to Medicare reimbursement for FQHCs in 1996 even though HCFA knew in 1996 that HRSA had abandoned the use of this standard and even though HCFA had never collected its

<sup>7</sup> National Association of Community Health Centers (NACHC) Issue Brief #92, January 2008



own productivity data for FQHCs. The District Court, therefore, concluded that CMS had never “actually evaluate[d] whether the 4,200 screen as applied to FQHCs complies with the Medicaid statute (or the Medicare statute, for that matter).”

Based on the absence of productivity standard requirements in the PPS statute or any subsequent CMS guidance, computing the PPS rates without imposing minimum productivity standards appears to more closely align with the intent of the statute. This approach is more favorable to providers due to higher PPS rates, which may result in higher program expenditures. Under the WVCHIP PPS, the baseline PPS rates will be calculated without imposing minimum productivity standards.

## **2.4 Inflation of Baseline PPS Rate**

Because the underlying cost data used to establish the PPS rates is several years old as of the PPS rate development, the WVCHIP will inflate the baseline PPS rates so that the implemented baseline PPS rates reflect an inflationary increase. The inflationary adjustment will bring the computed baseline PPS rates forward to October 1, 2009. Because the annual PPS rate inflationary adjustment is based on the Medicare Economic Index, the MEI will be used for the initial inflationary adjustment of the baseline PPS rates.

## **2.5 Prospective Nature of PPS Rates**

The PPS statute requires that reimbursement under the PPS consist of the PPS rate payment made on a per-visit basis. Subsequent CMS guidance to states in the form of questions and answers<sup>8</sup> stated the following:

The PPS methodology is prospective, and rates are not based on current costs or reconciled with those costs. The purpose of a PPS is to move away from cost reports and cost reconciliation.

Although the PPS rate is based on costs from the PPS base year(s), the PPS rate payment is the final payment for services rendered to patients under the program. Therefore, there is no reconciliation, in either the base year periods or any subsequent years, of the amount of reimbursement provided under the PPS with a provider’s actual costs.

## **3. Encounters**

### **3.1 Billable Encounters**

The billable patient visit, or “encounter”, is the fundamental element of the PPS reimbursement structure. With the exception of services that are carved out of the PPS rate (e.g. lab, radiology, etc.), PPS reimbursement is driven by the provision of a face-to-face encounter between a patient

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<sup>8</sup> CMS, Questions and Answers (Qs and As) on Medicaid PPS, October 2001



and a center or clinic practitioner (further discussion of practitioners below). Services that do not constitute a billable encounter are those services that do not meet this definition, such as laboratory, radiology, or pharmacy services, although these may either be bundled into the PPS rate or carved out and paid separately from the PPS rate (see section 2.2 above).

It is also important to define the services that do not constitute a face-to-face encounter. As noted previously, laboratory, radiology, and pharmacy services typically are not recognized as services that constitute an encounter. Other services that are typically not recognized as encounters include services such as a blood pressure measurement, blood draws for lab services, height/weight measurement, and other services incident to a professional service, or services provided by practitioners that do not provide face-to-face encounters. Additionally, services provided in an inpatient hospital or outpatient hospital setting do not constitute billable encounters.

For WVCHIP PPS reimbursement, an encounter is a face-to-face visit between a patient and an approved center or clinic practitioner as defined in section 3.2. An encounter is not recognized for services that are not included in the PPS rate and which may be separately billed, e.g., laboratory services, radiology services, prescription drugs, and services provided in non-FQHC/RHC service settings. An encounter is also not recognized for services and supplies incident to a professional service. Such items include medical supplies or other disposable medical products, sample medications not provided through a prescription, and services such as blood pressure measurement, obtaining a blood or urine sample, height/weight measurement, and any service that is incident to a professional service.

### **3.2 Eligible Practitioners (“core” practitioners that may provide an encounter)**

Another important component of encounter reimbursement is establishing the types of practitioners who are eligible to provide an encounter (sometimes referred to as “core” practitioners). Medicare’s policy is generally considered a suitable starting point, with expansion of the practitioner set as needed to correspond to state-specific covered services. Medicare policy recognizes the following practitioners as eligible to provide a face-to-face encounter:

- Physician
- Physician assistant
- Nurse practitioner
- Nurse midwife
- Visiting nurse
- Clinical psychologist
- Clinical social worker or other mental health professional.

States have expanded this list in accordance with state-specific covered services in FQHC/RHC settings to include additional practitioners, including the following:



- Psychiatrist
- Registered nurse
- Advanced practice registered nurse
- Dentist
- Dental hygienist
- Chiropractor
- Podiatrist
- Ophthalmologist
- Optometrist
- Therapist (physical, occupational, speech)
- Audiologist
- Nutritionist

Under the WVCHIP PPS, the following practitioners are considered approved, eligible practitioners who may provide a face-to-face encounter with a center or clinic patient:

- Physician
- Physician assistant
- Nurse practitioner
- Advanced practice registered nurse
- Registered nurse
- Visiting nurse
- Psychiatrist
- Clinical psychologist
- Clinical social worker
- Licensed professional counselor
- Dentist
- Dental hygienist
- Chiropractor
- Podiatrist
- Ophthalmologist
- Optometrist
- Physical, occupational, respiratory, or speech therapist
- Audiologist

If the WVCHIP adds a service benefit other than the current service benefit, and associated practitioners are deemed eligible to provide an encounter, the additional services may be eligible



for a change in scope of service adjustment in accordance with change in cope of services policies.

### 3.3 Eligible Encounter Services

In addition to establishing parameters relating to the services that do or do not qualify as encounters and the practitioners who are eligible to provide encounters, billing policies and instructions will also be issued so providers know the appropriate manner in which to bill encounter and non-encounter services. Providers must bill in accordance with WVCHIP billing instructions and national coding and billing standards. It is the responsibility of the provider to properly bill for services rendered. Reimbursement is limited to WVCHIP covered services as outlined in the WVCHIP Summary Plan Description (SPD). The PPS rate payment will be made for the professional service on the claim provided in a FQHC service setting. The PPS rate payment will not be made for excluded services (lab, radiology, prescription drugs), and these services will be reimbursed at the appropriate fee schedule rates. Providers should refer to the billing instructions for more information.

### 3.4 Encounter Restrictions and Limitations

Due to the encounter-based reimbursement structure of a PPS, provider billing of encounters must be clearly defined and restricted as necessary to prevent inappropriate billing and reimbursement, particularly for multiple services rendered on the same day. Medicare policy states the following regarding same-day encounters<sup>9</sup>:

Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when one of the following conditions exist:

- (1) After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment.
- (2) The patient has a medical visit and other health visit(s), as defined in paragraph (a) of this section [*i.e. behavioral health*].

Per the above policy, Medicare restricts encounters to one per day, unless the patient's diagnosis changes requiring a second visit, or for circumstances in which a patient receives a medical visit and a behavioral health visit on the same day. Using the same logic, many state PPS methodologies permit up to three encounters on the same day for a medical service, a dental service, and a behavioral health service. Similar to Medicare, many states also recognize multiple encounters if there are differing diagnoses such that an encounter occurring subsequent to the first encounter is for the treatment of a different condition. For dental services, while more than one dental service may be provided on the same day (e.g. dental cleaning and dental exam), dental services may also be limited to one encounter per day unless there is justification for a second encounter.

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<sup>9</sup> 42 C.F.R. 405.2463



Under the WVCHIP PPS, encounters with more than one eligible practitioner and multiple encounters with the same eligible practitioner that take place on the same day, at a single location, and that have the same diagnosis, constitute a single encounter, except when one of the following occurs:

- After the first encounter, the patient suffers a different illness or injury requiring additional diagnosis or treatment.
- The patient has a medical visit, a behavioral health visit, or a dental visit on the same day.

The medical necessity of multiple encounters must be clearly documented in the medical record. Providers must exercise caution when billing for multiple encounters on the same day, and such instances are subject to post-payment review to determine the validity and appropriateness of multiple encounters. Providers may not inappropriately generate multiple encounters by unbundling services that are routinely provided together during a single visit or scheduling multiple patient visits for services that could be performed at a single visit.

## **4. Change in Scope of Service**

### **4.1 Change in Scope of Service**

The PPS statute contains a provision for adjusting the PPS rate in the event the FQHC or RHC experiences an increase or decrease in the scope of services provided. The statute does not define a change in scope of service. However, in guidance to States on the implementation of Medicaid PPS<sup>10</sup>, CMS loosely defined a change in scope of service as “a change in the type, intensity, duration, and/or amount of services”. A change in scope of services is not simply an increase in costs or an expenditure outlay, such as for capital improvements or upgrades or renovations that do not result in a change in intensity, duration or amount of services. States have implemented a wide variety of definitions of changes that qualify for a change in scope of services adjustment, and below are examples of change in scope events from other state policies:

- Addition of a new service that is not present in the existing PPS rate
- Deletion of an existing service
- A change in service due to regulatory requirements
- A change in service resulting from opening, relocating, or remodeling a center or clinic site
- A change in sites or scope of services approved by the Health Resources and Service Administration (HRSA)
- A change in the type, intensity, duration, and/or amount of services due to a change in technology and/or medical practice

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<sup>10</sup> CMS, Questions and Answers (Qs and As) on Medicaid PPS, October 2001



- Change due to taxes, malpractice insurance premiums, or worker’s compensation insurance premiums

In addition to defining the events that qualify as a change in scope of service, other particulars are often included in a change in scope of service policy relative to assessing the magnitude of the change, identifying the length of time a change has been in effect before the adjustment to the rate will be implemented, and the timing of an adjustment to the rate.

Some states adjust the PPS rate for any change that meets the definition of a change in the scope of services, regardless of the magnitude of the change. Other states apply a threshold that a change in scope of services must meet or exceed in order for the PPS rate to be adjusted. Most threshold policies are percentage thresholds relating to the relationship of the scope change in terms of costs or the cost-per-visit to existing costs or the PPS rate, i.e. the change in scope must meet or exceed a certain percentage of existing costs or a certain percentage of the existing PPS rate. These percentages generally range from 1% to 5%.

Another common component of a change in scope of service methodology is a threshold time period during which the change in scope must be in existence before it will be reviewed or the PPS rate adjusted. The purpose of a threshold time period is to ensure that the scope change is a permanent change. These threshold time periods are typically 3 to 6 months.

A change in scope of service methodology should also specify when an adjustment to the rate is effective. Examples of effective dates utilized by other states include the date the change in scope of services occurred, the beginning of the fiscal year or calendar year in which the change in scope of services occurred, the beginning of the month after the change in scope of services occurred or a certain number of days or months after it occurred, or the date requested by the provider.

A PPS rate adjustment for a change in scope of services should account only for the change in scope event. The CMS questions and answers guidance relating to Medicaid PPS stated that a change in costs “is not considered in and of itself a change in the scope of services”<sup>11</sup>. Therefore, a change in the scope of services is not an adjustment to the PPS rate for any other changes the provider has experienced, such as an overall increase in costs or other changes in the provider’s cost structure. The provider’s cost report is usually the best tool for reviewing costs and visits relating to a change in scope of services (often in conjunction with other documentation collected from the provider). Adjusting the PPS rate to account for all changes in costs on the cost report would constitute in effect a complete rebasing of the PPS rate, which we do not believe was intended by the PPS statute.

Under the WVCHIP PPS, a change in scope of services may be recognized if any of the following events occur:

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<sup>11</sup> CMS, Questions and Answers (Qs and As) on Medicaid PPS, October 2001



- Addition of a new FQHC/RHC service that is not present in the existing PPS rate. Examples include dental services or behavioral health services.
- Deletion of an existing service
- A change in the type, intensity, or amount of services
- A change in service resulting from opening or relocating a center or clinic site
- A change in service due to federal or state regulatory requirements
- A change in sites or scope of services approved by the Health Resources and Services Administration (HRSA)
- Achievement of Patient Centered Medical Home (PCMH) designation

The following criteria must be met in order for a center or clinic to qualify for an adjustment to the PPS rate due to a change in scope of service:

- The change in scope of service must have been implemented continuously for six consecutive months.
- The cost attributable to a change in the scope of service, on a cost-per-visit basis, must account for an increase or decrease to the existing PPS rate of 5% or greater. To determine if the 5% threshold is met, the cost-per-visit specifically attributable to the scope change will be divided by the PPS rate in effect at the time the scope change has been implemented for six consecutive months.
- The costs relating to the change in the scope of service complies with Medicare reasonable cost principles.

The center or clinic must submit a request in writing to the WVCHIP for a change in scope of services review. The request must clearly specify the event(s) that occurred that the provider believes qualify for a change in scope of services review and for which a PPS rate adjustment is warranted. To be eligible for a PPS rate adjustment, the change in scope of service must have been implemented continuously for six consecutive months. The center or clinic must submit a copy of the Medicare cost report, and a detailed trial balance, for the cost reporting period in which the end of the six month implementation period falls.

If a change in scope of service is known in advance or planned, the center or clinic should notify the WVCHIP as soon as possible prior to the occurrence of the change in scope of service. Otherwise, if the center or clinic has not notified the WVCHIP of a planned change in scope of service prior to the change in scope occurrence, the center or clinic must notify the WVCHIP and submit the request for a change in scope of services review as soon as possible after the change in scope event. Providers must at a minimum submit the request for a change in scope of services review to the WVCHIP by the last day of the third month after the change in scope has been implemented for six consecutive months (a maximum of 9 months from the change in scope implementation). If the request is not submitted in the specified time frame, the PPS rate



will be effective on prospective basis only beginning on the first day of the calendar year following the calendar year in which the provider notifies the WVCHIP of the change in scope of services.

A review of a provider's change in scope of services request will take place within 90 days of the receipt of all required documentation. The WVCHIP will review the request and all submitted documents for completeness, accuracy and compliance with change in scope of service policies. Based on the review of the submitted documentation and any other relevant information, the WVCHIP will notify providers of the results of the review and whether an adjustment to the PPS rate is warranted.

If it is determined that a PPS rate adjustment is appropriate based on a change in scope of services, the cost-per-visit attributable to the change in scope of service will be applied to the PPS rate in effect at the time the change in scope of services has been implemented for six consecutive months. The adjusted PPS rate will be effective on the first day of the calendar year following the fiscal year in which the change in scope of service had been implemented for six consecutive months. If a change in scope of service request is not filed timely (by the last day of the third month after the change in scope has been implemented for six consecutive months), the adjusted PPS rate will be effective on a prospective basis only beginning on the first day of the calendar year following the calendar year in which the provider notifies the WVCHIP of the change in scope of services.

## **5. Other PPS Issues**

### **5.1 Behavioral Health Integration**

One of the expressed goals of the WVCHIP program is to encourage the integration of behavioral health services into FQHC and RHC primary care settings. In the context of PPS methodology, one of the primary ways a state Medicaid or CHIP agency can facilitate integration of behavioral health services in FQHC and RHC settings is to ensure that the system provides the appropriate recognition of encounters and PPS reimbursement for behavioral health services. This includes monitoring the allowable and billable services under the system to ensure that the desired behavioral health services can be billed by providers. Additionally, focus should be directed to the composition of the list of practitioners that may provide an encounter to ensure that a sufficient number of behavioral health practitioner types are included. For example, in addition to the baseline behavioral health practitioners present in Medicare's per-visit system and many Medicaid programs (clinical social worker and clinical psychologist), expansion of the list may be desired to include other behavioral health practitioners as a psychiatrist, a licensed professional counselor, a licensed behavioral practitioner, licensed alcohol and drug counselor, or other behavioral health professionals that provide face-to-face services with the patient.



Providers evaluating an integration of behavioral health services into their current practice will need to consider a wide variety of issues, including the following aspects of an integration program:

- Education of existing primary care practitioners to ensure they have the capability to interact with patients with behavioral health issues and are able to either treat the patient's needs or refer the patient to the appropriate behavioral health practitioner
- Encouragement of collaboration between physical health practitioners and behavioral health practitioners to provide a continuum of care and management of patients' physical and behavioral health needs
- Feasibility of contracting with other local providers, such as a hospital or other provider, to bring behavioral health practitioners to the center or clinic
- Modification of operational aspects, such as patient scheduling, length of appointments (can patients see both physical and behavioral health professionals during same visit), and the content and structure of patient charts and medical records
- Availability of assistance and guidance from entities such as HRSA that are promoting behavioral health integration

A review of behavioral health integration issues in other states may be helpful. An FQHC in Indiana entered into an arrangement with a Community Mental Health Center (CMHC). Under a reciprocal arrangement, the FQHC opened a site within the CMHC to provide physical health services to patients of the CMHC. The CMHC then provided its behavioral health staff on rotation arrangements to the FQHC's other service sites. Another helpful resource regarding integration efforts in other states is an April 2008 report published by the National Association of State Medicaid Directors (NASMD) and HRSA<sup>12</sup>. This report contains a discussion of various integration issues in the states of Delaware, Michigan, New Jersey, and Oklahoma.

Regardless of the integration approach, it will be beneficial to the success of the integration program for providers to coordinate with WVCHIP regarding their integration plans to ensure that the integration does not conflict with the PPS parameters. In this manner, WVCHIP can actively support and encourage behavioral health integration, while ensuring the integration programs meet the requirements of the PPS methodology.

## 5.2 Cost Report Collection

By definition, a PPS is prospective in nature and is not tied to costs, cost reconciliation, or ongoing submission of cost reports. However, on an ongoing basis the WVCHIP will collect cost reports annually from providers. Cost reports can be useful for monitoring provider costs in future years, such as to assess the relationship between costs and PPS rates, or to review information relating to a change in scope of services.

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<sup>12</sup> NASMD and HRSA Issue Brief, *Serving the Needs of Medicaid Enrollees with Integrated Behavioral Health Services in Safety Net Primary Care Settings*, April 18, 2008



### 5.3 FQHC and RHC Effective Dates

There are three types of centers who meet the definition of an FQHC: entities who are the recipients of grants under section 330 of the Public Health Service Act, entities who are not the recipients of section 330 grants but otherwise meet the requirements to receive a grant (referred to as FQHC look-alikes), and certain tribal health centers. HRSA is responsible for administering grants to those entities that qualify under section 330 of the Public Health Service Act. HRSA and CMS have a dual role in recognizing and certifying FQHC look-alikes.

Because of the dual Federal agencies involved in FQHC designation, confusion can arise as to the appropriate FQHC effective date of the center for state enrollment and reimbursement purposes. CMS has indicated to state Medicaid agencies that for FQHCs, the effective date is determined by the state at the time of the signed provider agreement, but the date can be back-dated to the HRSA grant date if the state elects to do so. However, CMS has specified that states may not require the Medicare enrollment date as the effective date of the Medicaid enrollment. Typically the CMS certification date for Medicare is the same as the HRSA grant date, but in the instance in which the Medicare certification date is later, the state may not restrict the effective date to the Medicare effective date. The WVCHIP will utilize the CMS certification date because in most cases it is the same as the HRSA date, and thus the WVCHIP enrollment date, CMS certification date, and HRSA grant date will be the same for the center. However, if CMS delays their certification resulting in a Medicare effective date that is later than the HRSA date, the state may want to utilize the HRSA grant date or the provider's CHIP enrollment date.

For FQHC look-alikes, the effective date is the date CMS certifies the center as meeting the requirements to receive a section 330 grant, and this date is typically noted in the FQHC certification letter from CMS to the center.

For rural health clinics, because the rural health clinic designation is a Federal designation (although it is achieved with input from state surveying agencies), the effective date for RHCs is typically the date CMS recognizes the clinic as a RHC.

Because the WVCHIP PPS methodology is effective for services provided on or after October 1, 2009, under no circumstances will a center or clinic be effective for WVCHIP PPS payment purposes prior to October 1, 2009.

### 5.4 Telemedicine

The use of telemedicine (electronic audio and/or visual equipment that permits health care practitioners to provide remote services to patients at a different location) may be particularly beneficial in rural areas where patients may have transportation difficulties or other barriers to accessing health care services. Telemedicine can also be an important component of behavioral health integration in FQHCs and RHCs as it may permit the provision of behavioral health services that may otherwise be difficult or not available. To the extent that FQHCs and RHCs provide telemedicine services, we believe these services should be considered allowable and



reimbursable. However, the underlying PPS parameters would still apply relative to the provision of an encounter.

In a telemedicine transaction, typically one provider acts as the “hub” site (where the practitioner is located) and another provider acts as the “spoke” site (where the patient is located). If the FQHC/RHC is the hub site where the practitioner is providing services to a patient in another location, a face-to-face encounter (via technology) is taking place. Medicare recognizes this as a billable visit, as do many other states. However, if the FQHC/RHC is the spoke site, i.e. the patient has presented at the site for evaluation or consultation with a practitioner located elsewhere, the FQHC/RHC at which the patient presents is not providing a face-to-face encounter. Therefore, the costs relating to the spoke-site services are allowable costs inclusive in the computation of PPS rates, but the services do not constitute encounters.

## **6. Managed Care Supplemental Payments**

### **6.1 Managed Care Supplemental Payments**

At this time, the WVCHIP does not contract with managed care organizations (MCOs) to provide managed care services to WVCHIP enrollees. However, this section includes a discussion of managed care supplemental payments in the event the program enters into such contractual arrangements in the future.

The PPS statute requires that under the prospective payment system, states must provide supplemental payments (or “wrap-around” payments) to FQHCs and RHCs for services provided under the center’s or clinic’s contract with a managed care organization (MCO). These supplemental payments are the difference between the reimbursement provided by the MCO and the amount that would have been paid under the PPS rate. These supplemental payments must be made no less often than every four months. The statute does not require that the supplemental payment that is made every four months be the final supplemental payment; thus, some states provide an interim supplemental payment at least as frequently as the statutory requirements, followed by a final reconciliation. Below are potential options for making these supplemental payments.

### **6.2 Interim Estimated Payments with Final Reconciliation**

A two-stage process has been implemented by some states that provides interim estimated payments in order to meet the frequency requirements of the statute. The interim payments can be based on claims experience available to the state or through a reporting process whereby the provider self-reports the claim activity that is eligible for supplemental payment. Because these are estimated interim payments, a periodic reconciliation is typically performed utilizing MCO claims data in order to determine the final accounting of the managed care claims activity for the



period, incorporating the MCO payments and the interim estimated supplemental payments, and resulting in a final settlement payment to or from the provider.

Because this option often utilizes provider self-reported information, providers should be required to attest to the validity and accuracy of the reported information. The primary benefit of this option is the provision of supplemental payments in a frequency that complies with the statute while minimizing programmatic resources (because a final reconciliation is typically calculated once per year). A significant downside to this option is the possibility of discrepancies between the data reported by providers for interim supplemental payments and the claims data from the MCOs used for the final reconciliation. Such discrepancies may arise due to encounters reported for supplemental payment that are denied by the MCO and thus not reported by the MCO to the state for the reconciliation. These data discrepancies can be minimized by requiring that the supplemental data reported by the provider reflect only adjudicated claims. However, there may still be discrepancies between provider and MCO data, as well as concerns regarding the completeness and accuracy of MCO claims, that require administrative resources to resolve.

### **6.3 Periodic Payment Based on Actual Claims Data**

Another manual supplemental payment approach consists of the calculation of actual/final supplemental payments on a periodic basis, meeting at a minimum the statutory frequency requirements. Instead of provider-self reporting, the supplemental payments are derived using MCO claims data. Because under this option the supplemental payment is the final payment, actual paid claims must be used as the basis for the calculation of the payment. A benefit of this approach is the avoidance of reliance on provider self-reported information. Concerns regarding the completeness and accuracy of the MCO claims data also exist under this option.

### **6.4 Supplemental Payment Made By Managed Care Organization**

Some states have tasked their contracted MCOs to make the supplemental payments directly without state involvement or calculations. This typically requires amending existing managed care contracts to include in capitation rates the funds for the MCOs to then reimburse the supplemental payments to providers. States have also made supplemental payments using the MCOs as a pass-through entity, in which case the capitation rates are not adjusted. Under this option, the MCO payments must be monitored by the state to ensure they are paid appropriately and in an amount that correctly reimburses the center or clinic at the level of their PPS reimbursement. Although some states have implemented this approach, at least one state was informed by CMS that this is contrary to the intent of the PPS statute because states are not permitted to require MCOs to make the supplemental payments.

### **6.5 Supplemental Payment Through State Payment System**

Another option involves the supplemental payments being made through the state's claims system. In this example, the MCO's paid claims are submitted to the state's claims system, and



the system computes the difference between the MCO payment and the PPS rate payment. The payment is made to the provider under the standard remittance and payment process for claims payments. This approach requires substantial modification to a state's claims system. However, once implemented, the result is an automated approach that provides real-time supplemental payments to the provider, ensures the state meets the supplemental payment frequency requirements, and does not require a periodic reconciliation.

