FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINIC SERVICES

All Federally Qualified Health Centers and Rural Health Clinics (hereinafter collectively referred to as "clinic/center") shall be reimbursed on a prospective payment system ("PPS") beginning October 1, 2012.

1. RATE DETERMINATION PROCESS FOR EXISTING FACILITIES

a. For facilities with an effective date prior to Fiscal Year ("FY") 1999, payment rates will be set prospectively using the total clinic/centers reasonable cost of furnishing core and other covered non-core services for FYs 1999 and 2000, adjusted for any change in scope, divided by the number of encounters for the two-year period to arrive at a cost per visit. For each calendar year thereafter, each clinic/center will be paid the per visit amount paid in the previous year, adjusted by the Medicare Economic Index ("MEI") as reported on January 1 and adjusted to take into account any increase (or decrease) in the scope of services furnished during the FY.

b. For facilities with an effective date on or after FY 2000, payment rates will be set prospectively using the total clinic/centers reasonable cost of furnishing core and covered non-core services divided by the number of encounters for the first full fiscal year of operations. The first full year of operations is defined as a final settled Medicare cost report, as adjusted for Medicaid services, that reflects twelve months of continuous service.

c. The calculation of the initial PPS rates and any subsequent adjustment to such rate shall be determined on the basis of reasonable costs of the center/clinic as provided under 42 CFR Part 413. Reasonable costs, as used in rate setting is defined as those costs that are allowable under Medicaid cost principles, as required in 45 CFR 92.22(b) and the applicable OMB circular. with no productivity screens or per visit payment limit applied to the rate. Reasonable costs do not include unallowable costs.

d. Unallowable costs are expenses incurred by a clinic/center that are not directly or indirectly related to the provision of covered services, according to applicable laws, rules and standards.

2. RATE DETERMINATION PROCESS FOR NEW FACILITIES

A "new" clinic/center is a facility that meets all applicable licensing or enrollment requirements on or after October 1 2012. Sites of an existing clinic/center that are newly recognized by HRSA are treated, for purposes of this State Plan, as a change in scope of services.

a. A new clinic/center must file a projected cost report to establish an interim initial base rate. The cost report must contain the clinic/center's reasonable costs anticipated to be incurred in the initial FY. The initial rate will be set at the lesser of eighty-percent (80%) of the pro forma allowable cost(s) as established by the interim cost report or the statewide average PPS rate of all existing providers within the same peer group, excluding the lowest and highest rate obtained from the current period.

b. A peer group is divided into three rate groupings; (1) FQHCs; (2) free-standing RHCs and (3) hospital based RHC facilities.

| TN No.: 19-001 | Approval Date: 07/01/2019 | Effective Date: 07/01/2019 |
| Supersedes: 12-012 |
c. Each new clinic/center must submit a Medicare cost report after the end of the clinic/center’s FY. An updated interim rate will be determined based on one hundred-percent (100%) of reasonable costs as adjusted for Medicaid services contained in the cost report. Interim rates will be adjusted prospectively until the Medicaid cost report is processed.

d. Each new clinic/center must submit a Medicare cost report (222 or 2552), reflecting twelve months of continuous service. The rate established shall become the final base rate for the center/clinic. The state will reconcile payments back to the beginning of the interim period applying the final base rate. If the final base rate is greater than the interim rate, the Bureau for Medical Services ("BMS") will compute and pay the clinic/center a settlement payment that represents the difference in rates for services provided during the interim period. If the final base rate is less than the interim rates, BMS will compute and recoup from the center/clinic any overpayment resulting from the differences in rates for the services provided in the interim period.

e. Under no circumstances may the base rate of a new facility exceed one hundred five percent (105%) of the statewide average PPS rate for all existing providers within the same peer group.

3. SERVICES CONSIDERED AN ENCOUNTER

The following services qualify as clinic/center encounters:

a. Covered Core Services are those services provided by:
   i. Physician services specified in 42 CFR 405.2412;
   ii. Nurse practitioner or physician assistant services specified in 42 CFR 405.2414;
   iii. Clinical psychologist and clinical social worker services specified in 42 CFR 405.2450;
   iv. Visiting nurse services specified in 42 CFR 405.2416;
   v. Nurse-midwife services specified in 42 CFR 405.2401;
   vi. Preventive primary services specified in 42 CFR 405.2448; and
   vii. Advanced Practice Registered Nurse specified in 42 CFR 440.166

b. Covered Non-Core Services
   All other ambulatory services, except for radiology, pharmacy, and laboratory services, as defined and furnished in accordance with the approved State Plan.

c. Services and supplies incidental to the professional services of encounter-level practitioners are included in the encounter rate paid for the professional services when the services and supplies are:
   i. Furnished as an incidental, although integral, part of the practitioner's professional services;
   ii. Of a type commonly furnished either without charge or included in the center/clinic bill;
   iii. Of a type commonly furnished in a provider's office (e.g. tongue depressors, bandages, etc.);
   iv. Provided by center employees under the direct, personal supervision of encounter-level practitioners; and
   v. Furnished by a member of the center's staff who is an employee of the center (e.g. nurse, therapist, technician or other aid).
d. A billable encounter is defined as a face-to-face visit between an eligible practitioner and a patient where the practitioner is exercising independent professional judgment consistent within the scope of their license.

e. An FQHC may bill for up to three separate encounters occurring in one day: one medical encounter, one behavioral health and one dental encounter per day per member may be billed; except in cases in which the member suffers illness or injury requiring additional diagnosis or treatment.

4. CHANGE IN SCOPE OF SERVICES RATE RECALCULATION

a. Pursuant to the following provisions, a change in scope of services related to the provision of Medicaid covered services may be recognized for a recalculation of the clinic/center’s rate if the clinic/center implements a qualifying event. The following events implemented by a clinic/center may be considered a qualifying event:
   i. Addition of a facility that is not present in the existing PPS rate. Relocation or renovation of a current facility present in the existing PPS rate is not a qualifying event;
   ii. Closure of a facility that is present in the existing PPS rate. Facility closures increasing the encounter rate will not be deemed as a qualifying event. Facility closures decreasing the encounter rate may be deemed as a qualifying event, but are subject to the standard deviation limitation in 4.f below;
   iii. Deletion of a service that is present in the existing PPS rate. Deletion of services increasing the encounter rate will not be deemed as a qualifying event. Deletion of services decreasing the encounter rate may be deemed a qualifying event, but are subject to the standard deviation limitation in 4.f below;
   iv. A change in service resulting from federal or state regulatory requirements specific to FQHC’s and/or RHC’s; OR
   v. Addition of a service that is not present in the existing PPS rate. Increases or decreases in patient volume for an existing service is not a qualifying event.

b. All of the following criteria must be met to qualify for a change in scope adjustment:
   i. The qualifying event must have been implemented continuously since its initial implementation;
   ii. When a qualifying event has been established, the PPS rate effective at the time of the change in scope start date (base rate) must increase or decrease at least 5% using the total allowable costs after twelve (12) consecutive months (“change in scope year”) of operations inclusive of the qualifying event. The base rate will be recalculated (“threshold rate”) using the Medicare cost report. The threshold rate will be calculated using the clinic/center’s reasonable total allowable cost of furnishing core and non-core covered services divided by the total number of encounters for the change of scope year. The threshold rate shall be determined by using the clinic/center’s reasonable costs provided under 42 C.F.R. 413; and
   iii. The cost related to the qualifying event shall comply with Medicare reasonable cost principles. Reasonable costs, as used in rate setting are defined as those costs that are allowable under Medicaid cost principles, as required in 45 CFR 92.22(b) and the applicable OMB circular, with no productivity screens or per visit payment limit applied to the rate. Reasonable costs do not include unallowable costs.

<table>
<thead>
<tr>
<th>TN No.</th>
<th>Approval Date: 07/01/2019</th>
<th>Effective Date: 07/01/2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>19-001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supersedes: 12-012</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
c. Each clinic/center will be responsible for notifying BMS of a qualifying event by the last day of the third month after the qualifying event has been implemented for twelve (12) consecutive months or a maximum of fifteen (15) months from the date of the qualifying event implementation. BMS will make all reasonable attempts to review and either approve or deny a clinic/center request by the last day of the third month after the request has been received by BMS with all sufficient documents as referenced in 4.d below. If BMS denies a request, the clinic/center may appeal the decision to the Secretary in writing within thirty (30) days, consistent with the provider appeal provisions in BMS’ policy manual.

d. Within sixty (60) days of the submission of the change in scope request, each clinic/center will be responsible for providing sufficient documentation, including any and all documentation requested by BMS, to support the review and request for a determination of change in scope.

e. Provided that all notification timeframes in 4(c) and (d) above are met and a qualifying event is established, the approved PPS rate will be retroactively applied back to the date the change in scope was implemented. A change in scope is implemented on the date of the first billable encounter at the new site and/or for the new service.

f. Failure to meet all the notification timeframes in 4(c) and (d) above shall result in the effective date of the approved rate to be the first day following the fiscal year end that the clinic/center submitted the documentation for the change in scope.

g. The threshold rate shall be limited to a maximum increase or decrease calculated using standard deviation amounts within the following three peer rate groupings: (1) FQHCs; Free-standing RHCs and Hospital-based RHCs.

Each peer group will be subdivided into two rate groups based upon the median rate. Median rates for each peer group will be established by BMS once per calendar year after adjustment and application of the MEI. The maximum threshold encounter rate will be calculated within each rate group utilizing a standard deviation range at, below or above the median delineated in Chapter 522 of the Bureau for Medical Services Provider Policy Manual.

h. A clinic/center may apply for a rate change due to a change in scope of services multiple times in a year. However, a clinic/center must wait for a minimum of twenty-four (24) months between implementing a higher encounter rate due to a change in scope of services. As an example:

- BMS grants clinic A an increased encounter rate of $150 due to a change in scope of services, with an effective date of January 1, 2020.
- Clinic A begins billing at the new encounter rate of $150 for dates of service on or after January 1, 2020.
- On January 1, 2021, clinic A implements a qualifying event, and for the following twelve (12) consecutive months the qualifying event is in place; also during the same twelve months, clinic A experiences at least a five percent (5%) increase in total allowable costs.

<table>
<thead>
<tr>
<th>TN No.:</th>
<th>19-001</th>
<th>Approval Date:</th>
<th>07/01/2019</th>
<th>Effective Date:</th>
<th>07/01/2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supersedes:</td>
<td>12-012</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
On January 1, 2022, clinic A requests an increased rate due to a change in scope of services. After reviewing it, BMS grants the request, increasing the encounter rate of clinic A to $175.

Normally, clinic A could begin billing at the increased $175 retroactively for dates of service on or after January 1, 2021 – the date the qualifying event/change in scope was implemented. However, in this example, since it last implemented an increased encounter rate pursuant to a change in scope of services on January 1, 2020, clinic A would not be able to begin billing at the new encounter rate of $175 until January 1, 2022.

BMS, in its sole discretion, may make exceptions to this twenty-four (24) month waiting period upon a demonstration of need by the clinic/center, including, but not limited to, federal grants, behavioral health substance use disorder services, and dental services.

5. **RECONCILIATION OF MANAGED CARE PAYMENTS TO THE PPS RATE**

Where a center/clinic furnishes services pursuant to a contract with a managed care organization, BMS will make supplemental payments to the extent required by Section 1902(bb)(5) of the Act.

**OTHER LABORATORY AND X-RAY SERVICES**

1. **Laboratory Services**

Payment shall be the lesser of 90% of the current Medicare established fee or the provider's usual and customary fee. All fees are published on the web at: [www.dhhr.wv.gov/bms](http://www.dhhr.wv.gov/bms).

The Bureau for Medical Services fee schedule rate is updated on January 1 of each year and is effective for services provided on or after that date. All rates are published on the web at: [www.dhhr.wv.gov/bms](http://www.dhhr.wv.gov/bms). Reimbursement shall be the same for governmental and private providers.

2. **X-Ray Services**

The following will apply to the technical component for radiology services:

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the service to the general public. The agency's fees were set as of January 1, 2008 and are effective for services on or after that date. All fees are published on the web at: [www.dhhr.wv.gov/bms](http://www.dhhr.wv.gov/bms). Except as otherwise noted in the plan, state developed fees are the same for both governmental and private providers.

<table>
<thead>
<tr>
<th>TN No.:</th>
<th>Approval Date: 07/01/2019</th>
<th>Effective Date: 07/01/2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>19-001</td>
<td>19-001</td>
<td>19-001</td>
</tr>
<tr>
<td>Supersedes:</td>
<td>12-012</td>
<td></td>
</tr>
</tbody>
</table>