

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499



Region III/Division of Medicaid and Children's Health Operations

SWIFT #121720124034

JAN 31 2014

Nancy V. Atkins, MSN, RNC, NP
Commissioner
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3706

RECEIVED
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COMMISSIONER BMS

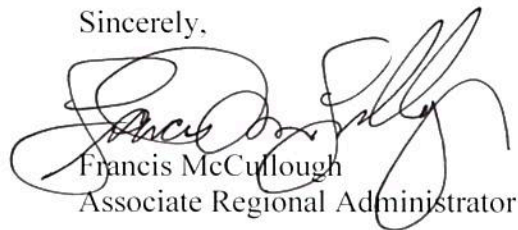
Dear Ms. Atkins:

We have reviewed State Plan Amendment (SPA) 12-012, Federally Qualified Health Centers, in which you propose to revise the definition of change in scope and covered services payable to Federally Qualified Health Centers and Rural Health Clinics.

This SPA is acceptable. Therefore, we are approving SPA 12-012 with an effective date of October 1, 2012. Enclosed are the approved SPA pages and signed CMS-179 form.

If you have further questions about this SPA, please contact Margaret Kosherzenko of my staff at 215-861-4288.

Sincerely,



Francis McCullough
Associate Regional Administrator

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER. 1 2 . 0 1 2	2. STATE. West Virginia
		3. PROGRAM IDENTIFICATION TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE October 1, 2012	
5. TYPE OF PLAN MATERIAL (Check One) <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: Social Security Act Section 1905(1)(1) and 1905 (1)(2)		7. FEDERAL BUDGET IMPACT: a FFY 2012 \$ 0 b FFY 2013 \$ 29,600,000	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Page 2, 2a, 2b, 2c, 2d, 2e, 2f		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (if applicable): Attachment 4 19-B, Page 2, 2a, 2b, 2c, 2d, 2e, 2f	
10. SUBJECT OF AMENDMENT: The purpose and rationale for this plan amendment is to revise the definition of change in scope and covered services payable to Federally Qualified Healthcare Centers ("FQHC") FQHC encounter code rates will still be subject to final cost settlement reviews.			
11. GOVERNOR'S REVIEW (Check One) <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED <input checked="" type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: <i>Nancy V. Atkins</i>		16. RETURN TO: Bureau for Medical Services 350 Capitol Street Room 251 Charleston West Virginia 25301	
13. TYPED NAME: Nancy V. Atkins, RN, MSN, NP BC			
14. TITLE: Commissioner			
15. DATE SUBMITTED: 12-17-12			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED 12/17/2012		18. DATE APPROVED JAN 31 2014	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2012		20. SIGNATURE OF REGIONAL OFFICIAL: <i>Frances McCullough</i>	
21. TYPED NAME: FRANCES McCullough		22. TITLE: Associate Regional Administrator	
23. REMARKS: 11/28/2014 Pen and ink changes made to Section # 8 Page Number of the Plan Section and Section #9 Page Number of the Superseded Plan Section eliminating pages 2e and 2f from each section. (mk)			

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Attachment 4.19-B

Page 2

4.19 Payments for Medical and Remedial Care and Services

1. a. 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.

RATE DETERMINATION PROCESS

1. INITIAL RATES

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 encounter 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.

1. 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.

2. 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. 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.

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- 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
 - c. Each new clinic/center must submit a Medicaid 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.
3. SERVICES CONSIDERED AN ENCOUNTER
The following services qualify as clinic/center encounters:
- a. Covered Core Services are those services provided by:
 1. Physician services specified in 42 CFR 405.2412;
 2. Nurse practitioner or physician assistant services specified in 42 CFR 405.2414;
 3. Clinical psychologist and clinical social worker services specified in 42 CFR 405.2450
 4. Visiting nurse services specified in 42 CFR 405.2416;
 5. Nurse-midwife services specified in 42 CFR 405.2401;
 6. Preventive primary services specified in 42 CFR 405.2448;
 7. Advanced Practice Registered Nurse specified in 42 CFR 440.166

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- 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:
 - 1. Furnished as an incidental, although integral, part of the practitioner's professional services;
 - 2. Of a type commonly furnished either without charge or included in the center/clinic bill;
 - 3. Of a type commonly furnished in a provider's office (e.g. tongue depressors, bandages, etc.);
 - 4. Provided by center employees under the direct, personal supervision of encounter-level practitioners; and
 - 5. Furnished by a member of the center's staff who is an employee of the center (e.g. nurse, therapist, technician or other aide).
- 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

- a. A change in scope of services is defined as a change in the type, intensity, duration and/or amount of services (a "qualifying event") provided by the clinic/center. A change in scope of service applies only to Medicaid covered services.

A change in scope of service may be recognized if any of the following qualifying events occur:

- 1. Addition of a new clinic/center service(s) that is not present in the existing PPS rate;
- 2. Closure of a facility that results in a change in scope in services offered by the health center;

TN No: 12-012 Approval Date: **JAN 31 2014** Effective Date: 10/01/12
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3. Deletion of an existing service;
 4. A change in service resulting from opening or relocating a center or clinic site;
 5. A change in service resulting from federal or state regulatory requirements;
- OR**
6. A change in sites or scope of project approved by the Health Resource and Services Administration ("HRSA").
- b. All of the following criteria must be met to qualify for a change in scope adjustment:
1. The qualifying event must have been implemented continuously since its initial implementation;
 2. The cost attributable to the qualifying event, on a cost per visit basis, must account for an increase or decrease to the existing PPS rate of five-percent (5%) or greater. To determine whether the threshold is met, the cost per visit of the year immediately preceding the cost reporting year in which the qualifying event occurs will be compared to the PPS rate in effect for the year in which the change in scope has been implemented for six (6) consecutive months; and
 3. The cost related to the qualifying event shall comply with Medicare reasonable cost principles. 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.
- 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 six (6) consecutive months or a maximum of nine (9) months from the date of the qualifying event implementation.
- d. 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. Providing that all notification timeframes in 4(c) and (d) above are met and a qualifying event is established, the adjusted PPS rate will be retroactively applied back to the date the change in scope was implemented.
- 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

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- g. the fiscal year end that the clinic/center submitted the documentation for the change in scope.
- h. A clinic/center may apply only once during any fiscal year for an adjustment due to a change in scope of service.

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.

6. Other Laboratory and X-ray Services

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.wvdhhr.org then medical services.

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.wvdhhr.org then medical services.

Reimbursement shall be the same for governmental and private providers.

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.wvdhhr.org then medical services. Except as otherwise noted in the plan, state developed fees are the same for both governmental and private providers.

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