CHAPTER 522 FEDERALLY QUALIFIED HEALTH CENTER (FQHC) AND RURAL HEALTH CLINIC (RHC) SERVICES

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BACKGROUND

The West Virginia Medicaid program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the program. This program, therefore, must also function within federally defined parameters.

Medicaid offers a comprehensive scope of medically necessary medical and mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all state and federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by the BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible, and complete documentation to justify medical necessity of services provided to each Medicaid member and made available to the BMS or its designee upon request.

The Center for Medicare and Medicaid Services (CMS) requires that all services provided to Medicaid members be medically necessary, cost effective, and provided in the appropriate setting by enrolled providers. As such, covered services are subject to nationally accredited, evidence-based medical necessity guidelines, including but not limited to the medical necessity criteria utilized by the BMS Utilization Management Contractor (UMC).

The National Correct Coding Initiative (NCCI) is used by West Virginia Medicaid as coding standards for procedures/services provided to Medicaid members. These standards, recommended by the CMS and compiled by the American Medical Association (AMA), apply to Current Procedural Terminology (CPT) numeric codes and the Healthcare Common Procedure Coding System (HCPCS) alpha-numeric codes. Services may also be subject to coding standards developed by the BMS and/or its fiscal agent. Providers must use the most current CPT, HCPCS, and International Classification of Diseases (ICD) diagnosis manuals applicable to the date of service when billing for services provided to Medicaid members. Providers are encouraged to implement Electronic Health Records (EHR). Information for EHR is available in *Chapter 100, General Administration and Information* or at the CMS website.

Section 6904 of Public Law 101-239 (the Omnibus Budget Reconciliation Act of 1989) amended the Social Security Act effective April 1, 1990, to add the Federally Qualified Health Center (FQHC) services under the Medicare program effective October 1, 1991, Section 1861(aa). This law established a core set of health care provider services. For the purposes of West Virginia Medicaid, FQHC look-alike facilities are subject to the same requirements set forth in this policy.

FQHCs are considered “safety net” providers that successfully increase access to care, promote quality and cost-effective care, improve patient outcomes, and are uniquely positioned to spread the benefits of community-based and patient centered care.

CHAPTER 522 FEDERALLY QUALIFIED HEALTH CENTER (FQHC) AND RURAL HEALTH CLINIC (RHC) SERVICES

In December 1977, Congress passed Public Law 95-210; the Rural Health Clinic (RHC) services Act. The Act authorized Medicare and Medicaid payments to certified rural health clinics for "physician services" and "physician-directed services" whether provided by physician, physician assistant, nurse practitioner, or certified nurse midwife. The Act established a core set of health care provider services.
The RHC must be located in a rural area that is designated as a shortage area. A shortage area is a defined geographic area designated by the US Secretary of Health and Human Services as having either a shortage of health services or a shortage of primary medical care.

POLICY

522.1 PROVIDER PARTICIPATION REQUIREMENTS

To participate in West Virginia Medicaid, FQHC and RHC facilities must be approved through the BMS fiscal agent contractor enrollment process and the appropriate Managed Care Organization, if necessary, prior to billing for any services. *Chapter 300, Provider Participation Requirements* presents an overview of the minimum requirements that health care providers must meet to enroll in and be reimbursed by the West Virginia Medicaid program. Additional participation requirements may be found in other chapters on the BMS Provider Manual website.

To become certified, FQHCs self-attest to their compliance with Medicare conditions for coverage [under 42 CFR §405 Subpart X, 42 CFR Part 491 Subpart A (except §491.3)], and are only surveyed by the CMS in connection with complaint investigations.

RHCs must be certified for participation in Medicare in accordance with 42 CFR Part 405 Subpart S. The US Secretary of Health and Human Services will notify the State Medicaid agency of the decision to approve or deny certification under Medicare (See 42 CFR §491.3 Subpart A).

FQHCs and RHCs are required to meet the same health and safety standards and are subject to monitoring and evaluation by all appropriate federal and state entities, and subject to all requirements outlined in this chapter. Please refer to the BMS Provider Manual, *Chapter 100, General Administration and Information* and *Chapter 300, Provider Participation Requirements*.

FQHC and RHC services are subject to review by the BMS Office of Program Integrity (OPI). When disallowances are discovered, the center/clinic will be subject to recovery of payment for services provided. Medical records must substantiate that any service billed to West Virginia Medicaid was provided to an eligible Medicaid member by an enrolled provider/practitioner. Documentation must be made available immediately to the BMS' designee upon request. For more information please refer to *Chapter 800, Program Integrity*.

In addition to requirements established in *Chapter 300, Provider Participation Requirements* and in 42 CFR §405.2402, FQHCs and RHCs must meet the specific requirements from WV State Code §16-2D-9 in order to participate and receive reimbursement from the BMS. The following additional documentation is required to be submitted to the BMS fiscal agent's Provider Enrollment Division and to be on file:

- Certificate of Need (CON) if rendering services in West Virginia OR a letter from the Health Care Cost Review Authority stating the FQHC or RHC is exempt from providing a CON.
- Newly enrolled FQHCs and RHCs must submit a projected cost report (similar to Medicare's cost reports CMS form 222 or CMS form 2552) to Medicaid.
- Fiscal year end-date.
- Current signed and dated DEA (Drug Enforcement Administration) certifications, if applicable, OR a signed letter stating the FQHC or RHC does not dispense drugs. (NOTE: DEA number is required for physicians under FQHC).
- Current Clinical Laboratory Improvement Amendments (CLIA) certificate OR a signed letter stating laboratory services are not provided.
- Current signed and dated Medicare certification and approval letter designating as a FQHC or RHC. Must be on Medicare letterhead and include the Medicare provider identification (ID) number and effective date of approval.
- If a facility has multiple physical sites under the same ownership, each of these physical sites must meet the enrollment criteria and be issued its own NPI number. They may not use the provider number issued to the main facility.
- Disclosure of participation in 340B Drug Pricing program and the Health Resources and Services Administration (HRSA) designated 340B ID number.
- A list signed and dated on provider letterhead, indicating which of the following categories of services are provided by the FQHC or RHC:
    - General practice/family practice
    - Pediatric services
    - Women's health services (e.g. OB/GYN, Family Planning)
    - Dental services
    - Vision services
    - Chiropractic services
    - Dermatology services
    - Pharmacy services
    - 340B Pharmacy services
    - Laboratory services
    - Radiology services
    - Behavioral health services
    - Other specialty services (specify service, e.g. orthopedics, podiatry)

Participating providers are responsible for familiarizing themselves with the policy manual's contents.

522.2 MEMBER ELIGIBILITY

It is the provider's responsibility to verify West Virginia Medicaid eligibility and obtain appropriate authorizations before services are provided. For verification of the member's eligibility and managed care coverage, providers may verify eligibility electronically or utilize the West Virginia Medicaid Voice Response System at 1-888-483-0793.

An FQHC or RHC may elect to make presumptive eligibility (PE) determinations for populations whose eligibility is determined using the Modified Adjusted Gross Income (MAGI) methodology described in

Chapter 10, Section 8 of the West Virginia Income Maintenance Manual. Refer to *Chapter 400, Member Eligibility* for additional information.

522.3 ENCOUNTERS

A billable encounter for an FQHC or RHC is defined as a face-to-face visit between an eligible practitioner and a member where the practitioner is exercising independent professional judgment consistent within the scope of their license.

Eligible practitioners include the following:

- Physician (Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO))
- Dentist (Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DDM))
- Optometrist
- Chiropractor
- Advanced Practice Registered Nurse (APRN)
- Nurse Practitioner (NP)
- Certified Nurse Midwife (CNM)
- Certified Nurse Specialist (CNS)
- Physician Assistant (PA)
- Psychiatrist
- Licensed Psychologist (LP) Master or Doctorate Level
- Licensed Independent Clinical Social Worker (LICSW)
- Licensed Certified Social Worker (LCSW)
- Licensed Graduate Social Worker (LGSW)
- Licensed Professional Counselor (LPC)
- Dental Hygienist providing services in the school setting outside of services identified in *Chapter 538, School-Based Health Services* through the West Virginia Department of Education (DOE) or a Local Education Agency (LEA)

The following services qualify as clinic/center encounters:

- Physician services specified in 42 CFR §405.2412
- APRN specified in 42 CFR §440.166
- PA services specified in 42 CFR §405.2414;
- Clinical Psychologist and Clinical Social Worker Services specified in 42 CFR §405.2450
- Visiting nurse services specified in 42 CFR §405.2416
- Nurse midwife services specified in 42 CFR §405.2414
- Preventive primary services specified in 42 CFR §405.2448

Additional information on specific health care encounters are documented in 42 CFR §405.2411, 42 CFR §405.2463 and 42 CFR §440.20 (b) and (c).

West Virginia includes additional Medicaid approved services in addition to federal services such as dental, vision, chiropractic, and/or behavioral health.

An FQHC or RHC encounter can also be a visit between a homebound patient and a Registered Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN) under certain conditions. Refer to Section 522.5, Visiting Nurse Services for information on visiting nursing services to homebound patients.

An FQHC encounter may be provided by qualified practitioners of outpatient Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) when the FQHC meets the relevant program requirements for provision of these services.

An FQHC may bill for up to three separate encounters per member occurring in one day:

1. One medical encounter;
2. One behavioral health encounter; and
3. One dental encounter

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

- After the first medical encounter, the patient suffers from an illness or injury requiring an additional diagnosis or treatment; or
- The patient has a behavioral health visit with an LP, LICSW, LCSW, LGSW under the supervision of the LICSW or LCSW, LPC; or
- The patient has a dental visit with the dentist.

An Initial Preventive Physical Examination (IPPE) or an Annual Wellness Visit (AWV) is considered an FQHC or RHC encounter. However, if it is provided in conjunction with another service, it may not be billed separately.

522.4 PROFESSIONAL SERVICES

Professional services other than physician services must be furnished by a PA, NP, CNM, CNS, LP, LICSW, LCSW, LGSW under the supervision of the LICSW or LCSW, and LPC to the member and include diagnosis, therapy, and consultation. These practitioners work under the medical supervision of a physician and in accordance with any medical orders for the care and treatment of a member prepared by a physician. The professional conditions are specified in 42 CFR §491.8(b) and are to be within their scope of their license and meet requirements of West Virginia State Law.

Professional staff that are authorized within their scope of license and practice within the West Virginia State Law to provide services for the FQHCs or RHCs must be directly employed or contracted with the FQHC or RHC prior to submitting all claims for reimbursement.

Reimbursement is made directly to the FQHC or RHC for covered services provided for members. These services must be performed at the FQHC or RHC facility or can be performed away from the facility by an enrolled/contracted practitioner whose agreement with the FQHC or RHC provides that they will be reimbursed by the facility for such services.

Behavioral health services must be provided by a contracted or employed Licensed Psychiatrist (MD/DO), LP, LICSW, LCSW, LGSW under the supervision of the LICSW or LCSW, or LPC who is authorized to provide behavioral health services in the center/clinic. All behavioral health services must be prior authorized.
DSMT and MNT services are considered FQHC services and are reimbursable as an encounter under the FQHC all-inclusive payment rate when rendered by qualified practitioners. DSMT and MNT services are billable FQHC encounters when the FQHC meets all program requirements for the provision of services as set forth in 42 CFR §410 Subpart H for DSMT and in 42 CFR §410 Subpart G for MNT The member must have a documented diagnosis of diabetes or renal disease. Current regulations only allow for FQHC reimbursement for individual face-to-face encounters DSMT and MNT services. FQHCs cannot be reimbursed for "group" DSMT or MNT. MNT and DSMT encounters cannot be billed on the same day.

Diabetes counseling or medical nutrition services provided by a registered dietician or nutritional professional at an RHC may be considered incident to a visit with an RHC provider provided all applicable conditions are met. DSMT and MNT provided under the Medicare coverage requirements are covered services when provided in an RHC. However, the actual delivery of these services does not constitute an RHC visit for purposes of billing, although the cost may be allowable on the Medicare cost report. DSMT and MNT services provided in an RHC are not eligible for payment as a visit.

Separate payment to RHCs for registered dieticians and nutritional professionals and services continues to be precluded. However, RHCs are permitted to become certified providers of DSMT services and report the cost of such services on their Medicare cost report.

Dental services in an FQHC or RHC are performed by general dentists, specialty dentists, and dental hygienists who may provide a variety of covered services in accordance with his/her licensure and in accordance with the WV State Code Chapter 30, Article 4, and 4A and West Virginia State Code §30-4-11. Coverage decisions are based upon the member's age, medical necessity, and the member's need.

Enrolled children up to 21 years of age are eligible for covered diagnostic, preventive, restorative, periodontics, prosthodontics, maxillofacial prosthetics, oral and maxillofacial surgery, and orthodontics. Covered dental services for enrolled adults over the age of 21 are limited to emergent procedures to treat fractures, reduce pain, or eliminate infection.

Vision services in an FQHC or RHC are performed by an optometrist or an ophthalmologist in accordance with *Chapter 525, Vision Services*.

Chiropractic services in an FQHC or RHC are performed by a chiropractor in accordance with *Chapter 519 Practitioner Services, Policy 519.7 Chiropractic Services*.

522.5 VISITING NURSE SERVICES

Visiting nurse services are covered if the FQHC or RHC is located in an area in which the US Secretary of Health and Human Services or his or her delegate has determined that there is a shortage of home health agencies. The services are rendered to a homebound individual without access to a home health agency.

The services are furnished by an RN, LPN, or LVN that is employed by, or receives compensation for the services from the clinic. The LPN or LVN must work under the supervision of an RN and the RN must work under the supervision of the enrolled or contracted physician. See 42 CFR §405.2417

Homebound is an individual who is permanently or temporarily confined to his or her place of residence because of a medical or health condition. This individual may be considered homebound if he or she leaves their place of residence infrequently. "Place of Residence" does not include a hospital or long-term care facility. The member is provided with nursing care on a part-time or intermittent basis by an RN, LPN, or LVN that is employed by or receives compensation for the services from the facility. 42 CFR §405.2416

The services must be furnished under a written treatment plan that is established, reviewed, and must be signed/dated every 60 days by an RHC supervising physician, APRN, PA, and CNM. The nursing care provided must be for the safety of the patient and assure that physician orders are implemented. Communication of the team must be documented in the member's treatment plan. These homebound services include assisting with activities of daily living (ADLs), implementing a system for taking medications, accessing and maintaining central and peripheral line for medications administration, and wound care are services provided by home health. Household and housekeeping services or other services that would constitute custodial care are not included in visiting nurse services.

522.6 INCIDENTAL SERVICES

Incidental practitioner services provided in an FQHC or an RHC are included in the facility's reimbursement and are not separately billable.

Services and supplies incidental to the services of encounter-level practitioners included in the encounter rate are:

- Furnished as an incidental, although integral, part of the practitioner's professional services;
- Of a type commonly furnished either without charge or included in the FQHC or RHC bill;
- Of a type commonly furnished in a provider's office or center/clinic;
- Furnished under the physician's direct supervision by a member of the FQHC or RHC staff who is an employee of the center (e.g. nurse, therapist, technician, or other aide);
- Furnished drugs and biologicals that are not usually self-administered, covered preventive injectable drugs (e.g., influenza, pneumococcal)
- Bandages, gauze, oxygen, and other supplies; or
- Assistance by auxiliary personnel such as a nurse, medical assistant, or anyone acting under the supervision of the physician.

522.7 SERVICE LIMITATIONS

The following limitations and requirements apply to services provided by FQHC and RHC facilities:

- If two unrelated medical encounters occur on the same day, documentation must be accompanied with the claims and submitted directly to the appropriate fiscal agent.
- If a member is seen in the center/clinic and admitted to an acute care hospital on the same day as the center/clinic visit, documentation must be provided with the claims and submitted directly

to the appropriate fiscal agent. FQHC services are not covered in a hospital as defined in §1861E1 of the Social Security Act.

- LP, LICSW, LCSW, LGSW under the supervision of the LICSW or LCSW, and LPC services are limited to those services provided to members in or on behalf of the center/clinic. All behavioral health visits are to be **prior** authorized by the UMC.
- Dental services in the school setting must be provided initially by the dentist. Subsequent visits are allowed with the dental hygienist on an alternating basis. Preventive oral health services provided by a dental hygienist with a public health practice permit (West Virginia State Code §30-4-11-5) are exempt from this requirement.
- Supplies, materials, and all drugs that are administered to the Medicaid member during the encounter, are considered a part of the physician's or other health care practitioner's service and are all inclusive in the per-encounter rate.
- Clinical Laboratory Improvement Amendments' designated laboratory procedures, performed by an FQHC or RHC, are considered part of the practitioner's service and are included in the per-encounter rate. A list of CLIA waived designated tests can be found on the CMS website. If additional laboratory testing is required and is not part of the encounter fee, the independent certified laboratory must be enrolled with West Virginia Medicaid to perform any additional testing and may be reimbursed for the services.
- Radiology services have a professional and technical component. The professional component (identified by modifier 26) represents the portion of the service associated with the physician's interpretation of the test. The technical component (identified by modifier TC) represents the portion of the service associated with the performance of the test. The physician may be paid for the professional component while the facility where the radiology service is furnished may be paid for the technical component. The physician is paid for both components if they perform and interpret the service at the center/clinic. All fees are published on the BMS website.

522.8 TELEHEALTH SERVICES

Telehealth is not a telephone conversation, email, or faxed transmission between a healthcare provider and a member, or a consultation between two healthcare providers. The member must be able to see and interact with the off-site provider at the time services ("real-time not delayed") are provided through Telehealth. Services provided through videophone or webcam are not covered. Please refer to *Chapter 519 Practitioner Services, Policy 519.17 Telehealth Services* for additional information.

FQHCs or RHCs may serve as an originating site for Telehealth services, which is the location of the Medicaid member at the time the service is provided through a telecommunications system. Enrolled FQHCs or RHCs that serve as an originating site for Telehealth services are paid an originating site facility fee.

FQHCs or RHCs may now serve as a distant site for Telehealth consultations by a psychiatrist or psychologist only and be reimbursed at the encounter rate. The distant-site practitioner must bill the appropriate Current Procedural Technology/Healthcare Common Procedure Coding System (CPT/HCPCS) code with the appropriate Place of Service (02) on a HCFA1500 form.

522.9 SERVICES PROVIDED IN THE SCHOOL SETTING

Services may be provided in the school setting through an FQHC or RHC facilities. These facilities may provide services such as preventive care, behavioral health, health education, and dental care to children and adolescents in an effort to provide better access to services while the member is in school. These services are reimbursed by West Virginia Medicaid as a "face-to-face" encounter by the facility. These services are outside of those provided through the West Virginia DOE or a Local Education Agency (LEA) identified in *Chapter 538, School-Based Health Services* of the BMS Provider Manual.

522.10 SERVICES BILLED OUTSIDE THE ENCOUNTER

The following specific preventive services have a technical component not included in the encounter fee that can be billed in addition to the encounter on a HCFA 1500:

- Screening pap smears and screening pelvic exams
- Prostate cancer screening
- Colorectal cancer screening tests
- Screening mammography
- Bone mass measurements
- Glaucoma screening

The professional component is the FQHC or RHC service performed by the facility's physician or non-physician practitioner and is normally reimbursed in the encounter fee. The professional component for insertion of long acting reversable contraceptive devices and the devices may be billed outside the encounter. See *Chapter 519, Section 519.15 Reproductive Health Services* for more information.

Certain services are not considered FQHC or RHC services either because they are not included in the FQHC or RHC benefit or are not a Medicare benefit. Non-covered FQHC or RHC services include but are not limited to:

- Ambulance services
- Outside laboratory services - Although FQHCs and RHCs are required to furnish certain laboratory services (for RHCs, see section §1861(aa)(2)(G) of the Act) those laboratory services are not within the scope of the FQHC or RHC benefit.
    - 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.
    - When centers or clinics separately bill laboratory services, the cost of associated space, equipment, supplies, facility overhead, and personnel for these services must be adjusted out of the FQHC or RHC Medicare cost report.
- Prosthetic devices that replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care, and the replacement of such devices
- Durable medical equipment including crutches, hospital beds, and wheelchairs used in the patient's place of residence, whether rented or sold
- Orthotic devices such as leg, arm, back, and neck braces and artificial legs, arms, and eyes, including replacements, if required, because of a change in the patient's physical condition

- Physical, speech, or occupational therapy or supplies provided by a therapist not employed or contracted by the FQHC or RHC
- Medicare excluded services for adults 21 years and older including routine dental care, hearing tests, eye exams, etc.
- Technical components of diagnostic tests not listed above. 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.

522.11 PRIOR AUTHORIZATION REQUIREMENTS

It is the responsibility of the enrolled treating, prescribing, ordering, or referring practitioner to submit all requests for covered services requiring prior authorization to the UMC for medical necessity determination. Nationally accredited, evidence-based, medically appropriate criteria, such as InterQual, or other medical appropriateness criteria approved by the BMS, is utilized for reviewing medical necessity of services requested.

Retrospective authorization is available by the UMC in the following circumstances:

- A procedure/service denied by the member's primary payer, providing all requirements for the primary payer have been followed, including appeal processes; or
- Retroactive West Virginia Medicaid eligibility.

Behavioral health encounters in an FQHC or RHC require prior authorization for all visits by the psychiatrist, APRN with mental health specialty, LP, LICSW, LCSW, LGSW under the supervision of the LICSW or LCSW, and LPC who are employed/contracted (with the FQHC or RHC) to provide these services.

522.12 FQHC FACILITIES PARTICIPATING IN THE 340B PROGRAM

Section 340B of the Public Health Services Act of 1992 provides access to deeply discounted drugs for certain provider entities who meet the qualifications for participation in the 340B program, as established by the HRSA. This program allows participating providers, including eligible FQHCs and hospitals, to offer medications to their patients at deeply discounted prices.

Per federal law, drugs with discounts generated from participation in the 340B program, are not eligible for Medicaid federal drug rebates and drug claims from these provider entities must be exempted from Medicaid drug rebate invoicing. All provider entities must submit their Actual Acquisition Costs (AAC) when billing for drugs purchased under the 340B program when billing claims to West Virginia Medicaid. Submission of drug purchase invoices may be required for audit purposes.

All covered entities must ensure that the drugs purchased through this program are used for **outpatients only**. This program does not apply to drugs supplied to inpatients. Covered entities are prohibited from transferring or reselling 340B purchased drugs to individuals who are not patients of the facility. The entity

is responsible for implementing systems to ensure compliance and maintain documentation of these practices.
All entities must apply to HRSA for participation in the 340B program. At the time of application, providers must determine whether they will use 340B drugs for their Medicaid patients (carve-in) or whether they will purchase drugs for their Medicaid patients through other sources (carve-out).

- Entities that carve-in are required to inform HRSA of their decision by providing their Medicaid provider number/National Provider Identifier (NPI) at the time they enroll in the 340B program that they will purchase and dispense 340B drugs for their Medicaid patients. If covered entities bill Medicaid for drugs purchased under 340B, then **ALL** drugs billed with that number must be purchased under 340B and that Medicaid provider number/NPI must be listed on the HRSA Medicaid Exclusion File.
- In addition to the HRSA application process, the BMS requires that participating 340B program providers certify their participation by completing the required 340B Certification Form.
- Entities that opt to carve-out of the 340B program must purchase drugs from another source and that Medicaid provider number/NPI should not be included on the HRSA Medicaid Exclusion File.

HRSA maintains a current listing of eligible providers on the HRSA website. It is the providers' responsibility to verify that the HRSA listing of their participation is current and accurate. Providers must report any changes in Medicaid 340B program participation to HRSA and to the BMS before implementing this change. A written notice of a change in participation must be received no later than 30 days prior. Notices must be sent to:

Bureau for Medical Services
Attn: Pharmacy Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301

522.13 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

FQHC and RHC facilities must comply with the documentation and maintenance of records requirements described in *Chapter 100, General Administration and Information, Chapter 300, Provider Participation Requirements, Chapter 503, Licensed Behavioral Health Centers Chapter 521, Behavioral Health Outpatient Services* of the BMS Provider Manual.

522.14 REIMBURSEMENT METHODOLOGY

All FQHCs and RHCs shall be reimbursed on a Prospective Payment System (PPS). The calculation of PPS will conform to section 1902(bb) of the Social Security Act (The Act).

The FQHC and RHC reimbursement structure is encounter-based. Facility-specific rates are established for each FQHC and RHC and are paid for services eligible for an encounter payment. Services not eligible for an encounter payment are paid at the appropriate fee schedule amount.

The BMS bases FQHC and RHC reimbursement on the CMS approved Medicaid State Plan. CMS only permits reimbursement based upon reasonable costs for services defined in the West Virginia Title XIX State Plan or in Section §1861(aa)(1)(A)(C). Reasonable costs do not include unallowable costs, which

are expenses incurred by a center/clinic that are not directly related to the provision of covered services, according to applicable laws, rules and standards. Allowable costs must be reasonable and necessary and may include practitioner compensation, overhead, equipment, space, supplies, personnel, and other costs incident to the delivery of the FQHC or RHC services.

The facility-specific encounter rate is calculated as follows for facilities with an effective date:

1. Prior to October 1, 2012 - reference process outlined in West Virginia State Plan Amendment (SPA) Section 1, *Rate Determination Process for Existing Facilities*
2. October 1, 2012 thru June 30, 2019 - reference process outlined in SPA Section 2, *Rate Determination New Facilities*
3. On or after July 1, 2019 - same criteria as outlined in SPA Section 2, *Rate Determination New Facilities* with the additional requirement that under no circumstances may the base rate of a new facility exceed 105% of the statewide average PPS rate for all existing providers within the same peer group. The peer groups are FQHCs; Free-standing RHCs; and Hospital-based RHC facilities.

Refer to *Chapter 300, Provider Participation Requirements* and *Chapter 600, Reimbursement Methodologies*, for additional information related to reimbursement.

522.15 CHANGE OF SCOPE OF SERVICES

A change of scope of services is defined as a change in the type, intensity, duration, and/or amount of services (a “qualifying event”) provided by the center/clinic. A change of scope of services applies only to West Virginia Medicaid covered services. **Note: A change in costs alone does not constitute a change in scope of service.**

Pursuant to the following criteria, a change in scope of services related to the provision of Medicaid covered services may be recognized for a recalculation of the clinic’s/center’s rate if the clinic/center implements a qualifying event. The following events implemented by a clinic/center shall be considered a qualifying event:

- 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;
- 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 listed below;
- 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 listed below;
- A change in service resulting from federal or state regulatory requirements specific to FQHCs and/or RHCs; OR
- 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.

All of the following criteria must be met to qualify for a change in scope adjustment:

- The qualifying event must have been implemented continuously since its initial implementation;
- 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 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 FQHC's/RHC'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 FQHC's/RHC's reasonable costs provided under 42 C.F.R. 413; and
- 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.
- Each FQHC/RHC will be responsible for notifying BMS, in writing on company letterhead, of a qualifying event by the last day of the third month after the qualifying event has been implemented for 12 consecutive months or a maximum of 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 referenced below. If BMS denies a request, the clinic/center may appeal the decision to the Commissioner in writing within 30 days, consistent with the provider appeal provisions in BMS' policy manual.
- Within 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.
- Provided that all notification timeframes 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.
- Failure to meet all the notification timeframes 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.
- A clinic/center will be eligible to receive approval for only one change in scope request per fiscal year. However, a clinic/center must wait for a minimum of 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 12 consecutive months the qualifying event is in place; also, during the same 12 months, Clinic A experiences at least a five percent (5%) increase in total allowable costs
    - 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 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.

Threshold Rate: The threshold rate shall be limited to a maximum increase or decrease calculated using standard deviation amounts within the following three peer rate groupings: 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.
- The Peer Group standard deviation amounts effective July 2019 are:
  - FQHCs: Below Median = 1.5 Above Median = 1.0
  - Free-standing RHCs: Below Median = 2.0 Above Median = 1.5
  - Hospital-based RHC facilities: Below Median = .75 Above Median = 1.0

Requests for review of a qualifying event should be sent to the following address:

West Virginia Department of Health and Human Resources
Office of Accountability and Management Reporting (OAMR)
One Davis Square, Suite 304
Charleston, WV 25301

522.16 MANAGED CARE PAYMENTS

If the individual is a member of a Medicaid Managed Care Organization (MCO), the provider must follow the MCO's prior authorization requirements and applicable rules related to MCO covered services and submit claims to the MCO. The MCO must reimburse the FQHC/RHC at the same encounter rate paid by BMS.

522.17 REPORTING REQUIREMENTS

Providers are required to timely file their Medicare cost reports for Title XIX services. A timely filed report for providers that are required to submit an annual Medicare cost report must be received in accordance with the "cost report due date." Reporting requirements for FQHCs and RHCs are as follows:

- Each center/clinic must submit an as-filed Medicare cost report after the end of the center/clinic fiscal year, as defined as the first full year of operation, as adjusted for Medicaid services that reflect 12 months of continuous service.
- Each new center/clinic that meets all applicable licensing or enrollment requirements on or after October 1, 2012 must submit a Medicare cost report, reflecting 12 months of continuous service.
- Medicare cost reports are considered to be timely filed when received on or before the applicable due date at the following address:

West Virginia Department of Health and Human Resources
Office of Accountability and Management Reporting (OAMR)
One Davis Square, Suite 304
Charleston, WV 25301

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

Allowable Costs: Costs that are incurred by a center/clinic, and are reasonable in amount and proper, and necessary for the efficient delivery of the FQHC and RHC services.

Certified Diabetes Educator (CDE): A CDE is a health care professional who is specialized and certified to provide diabetes education and self-management skills to Medicaid members.

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

Encounter: 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.

Diabetes Self-Management Training (DSMT): Training to teach Medicaid members to cope with and manage diabetes. It includes tips for eating healthy, being active, monitoring blood sugar, taking medication, and reducing risks.

Federally Qualified Health Center (FQHC): An entity that has entered into an agreement with CMS to meet Medicare program requirements under 42 CFR §405.2434 and is receiving a grant under section 329, 330, or 340 of the Public Health Service Act, or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under section 329, 330 or 340 of the Public Health Service Act". FQHCs may be free-standing or hospital-based facilities. An FQHC is a federal designation from the Bureau of Primary Health Care (BPHC) and CMS that is assigned to private non-profit or public health care organizations.

Federally Qualified Health Center Look-Alike: An organization that meets all of the eligibility requirements of an FQHC that receives a PHS Section 330 grant but does not receive grant funding or Federal Torts Claims Act (FTCA) provider liability coverage.

Homebound: Homebound is an individual who is permanently or temporarily confined to his or her place of residence because of a medical or health condition. The individual may be considered homebound if he or she leaves the place of residence infrequently. For this purpose, "place of residence" does not include a hospital or long-term care facility.

Prospective Payment System (PPS): A method of reimbursement in which payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services).

Public Health Service Act (PHS Section 330): Defines federal grant funding opportunities for organizations to provide care to underserved populations. Types of organizations that may receive 330 grants include: Community Health Centers, Migrant Health Centers, and Health Care for the Homeless programs, and Public Housing Primary Care programs.

Reasonable Cost: 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 applied to the rate. Reasonable costs do not include unallowable costs.

Reporting Period: A period of 12 consecutive months or time frame specified by the intermediary as the period for which a clinic or center must report its costs and utilization. The first and last reporting periods may be less than 12 months.

Rural Health Clinic (RHC): A facility authorized (by Section 1102 of the Social Security Act, the Secretary of the Treasury, the Secretary of Labor, and the US Secretary of Health and Human Services, respectively, shall make and publish such rules and regulations) as a clinic that is located in a rural area designated as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases, and meets all other requirements of this subpart. RHCs may be free-standing or hospital-based facilities. The facility is certified to receive Medicare and Medicaid reimbursement and meet Medicare program requirements under 42 CFR §405.2402.

School-Setting Health Services: The FQHC or RHC providing covered services on or adjacent to a school property.

Shortage Area: A geographic area designated by the Secretary of Health and Human Services Department as having either a shortage of personal health services (under section 1302(7) of the Health Service Act) or a shortage of primary medical care manpower (under section 332 of the Act).

Technical Component: The physical part of attaining the specimen, performing procedure, or taking the x-ray. Technical component services are identified with the modifier -TC and are normally payable to facilities.

Telehealth Services: Health care services provided through advanced telecommunications technology from one location to another. Medical information is exchanged in real-time communication from an Originating Site, where the participant is located, to a Distant Site, where the provider is located, allowing them to interact as if they are having a face-to-face, "hands-on" session.

Unallowable Costs: Expenses incurred by the center/clinic that are not directly or indirectly related to the provision of covered services, according to applicable laws, rules, and standards.

Visiting Nurse Services: Part-time or intermittent nursing care and related medical supplies (other than drugs or biological) provided by an RN, LPN, or LVN to a homebound patient.

REFERENCES

The West Virginia State Plan references FQHC and RHC services at sections 3.1-A(2)(b) and (c), 3.1-B(2)(b) and (c), supplement 2 to attachments 3.1-A and 3.1-B(2)(b) and (c) and reimbursement at 4.19-B(2)(b) and (c).

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter	Federally Qualified Health Center and Rural Health Clinic Services	December 1, 2015
Entire Chapter	Updated language throughout and reorganized sections. Telehealth Services – Added new policy to allow FQHC/RHC distant site for Psychiatrists and Psychologists Added language regarding reimbursement of LARC professional fees and devices Clarified Change of Scope of Services Section	July 1, 2019