SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Nikki R. Haley GOVERNOR
Christian L. Soura DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

July 25, 2016

COMMENTS REGARDING PROPOSED PUBLIC NOTICE FOR FQHC PAYMENT METHODOLOGY PUBLISHED May 25, 2016

"1. RHS Requests a 90-day delay in the implementation of the proposed changes to allow continued dialogue between SCDHHS and the SC FQHCs to determine the remaining details, comprehend, and budget for the proposed changes.
2 RHS requests that SCDHHS consider lifting the current administrative cap and productivity screen that have not been justified and was not used in the determination of the Medicare PPS rate.
3 RHS requests that SCDHHS provide more accountability of the MCOs to reimbursement obligations to FQHCs regarding claims processing of all eligible claims, case flow effect and provider MLR comparisons without causing harm to FQHCs."

"We are concerned that SCDHHS's proposal does not provide adequate protections for South Carolina's FQHCs, as it fails to set a baseline PPS rate and provides no detailed way to adjust that rate going forward. In addition, we are concerned the new APM proposal will not adequately take into account FQHCs' true costs, has a limited change in scope provision, and fails to address issues with managed care reimbursement. Therefore, RHC requests a 90-day delay in the implementation of the proposed changes to allow for continued dialogue between state FQHCs and SCDHHS."

"As SCDHHS moves to setting a new APM rate for each FQHC, which is a prospective rate that is not subject to annual reconciliation (as opposed to the current "APM" that relies upon year-end reconciliation), there are a number of issues we would like for you to keep in mind:
A. Recognizing appropriate costs
B. Specific Cost Limitations
Change in Scope (CIS) Policy
Protections in Managed Care:
A. Background
B. Balanced Budget Amendment changes to Harmonize Managed Care and FQHCs
C. CMS's Long-Standing Interpretations of BBA Provisions
D. Paid Claims Policies
Out of Network Requirements
Conclusion
Based on our concerns described above, as well as the numerous changes that are not yet fully developed we respectfully ask:
1. That SCDHHS delay implementation of the proposed changes for up to 90 days to allow continued dialogue between SCDHHS and the state FQHCs to comprehend and plan for the proposed changes.
2. That SCDHHS comply with the legal standards discussed above in making any changes to the FQHC reimbursement system.
3. That SCDHHS provide more accountability of the MCOs to reimbursement obligations to FQHCs without causing harm in terms of provider MLR comparisons."

SCDHHS Responses:

- **The July 1, 2016 ARM PPS rates were provided to the SC Primary Health Care Association on April 11, 2016. There were two separate meetings prior to the release of the rates which discussed how the rates were determined, the proposed changes relating to scope of services, and how managed care would be impacted. In addition, this action was officially announced in the February 9, 2016 MCAC meeting. There have been multiple subsequent meetings and conversations between SCDHHS and the FQHCs and/or their associations.**

- **The SCDHHS acknowledges that the baseline PPS rates have not been adjusted to take into account any agency defined scope of services changes. However, the history of the rate changes over the years show that not only did the agency account for any agency defined scope of service changes under the APM cost based rates but also accounted for 100% of the direct service costs increases and a portion of the allowable overhead cost increases that occurred over the years. The APM actual cost rates from baseline 2001 to 2014 increased on average 75% while baseline PPS rates from 2001 to 2014 increased on average 29% (with no scope of service change). Therefore it is safe to say that on average, actual cost increases reflected in the APM cost based rates reflected actual trend growth in excess of what the MEI allowed over time.**

- **The July 1, 2016 APM PPS rates (based upon provider year end 2014 cost reports) will allow for medical costs associated with physicians and midlevel practitioners, in-house lab, x-ray professional services, dental, podiatry, behavioral health, health education, nutrition, medical social work, chiropractic services, and clinic administered drugs incurred during an encounter visit. They will also include an allowance for overhead costs.**

- **The Medicaid Agency has always reimbursed FQHCs for Medicaid covered services through the APM cost based rate and will continue to do so via the APM PPS rate. We do use Medicare allowable cost definitions in the determination of allowable costs as well as the minimum productivity levels for physicians and midlevel practitioners. However the APM PPS rates as well as the cost based APM rates always represented payment for and included the costs of Medicaid covered FQHC services.**

- **The Medicaid Agency is not implementing the baseline PPS rates as established by BIPA 2000. The Medicaid Agency is establishing APM PPS rates which consider all scope of service changes that the provider has incurred up through 2014. SC Medicaid defined scope of service changes have been defined and will allow for reimbursement of scope of service changes incurred by a provider after their specific 2014 cost report year end.**

- **The Medicaid Agency is allowed to determine what reasonable costs are and the use of productivity screens and overhead allowances provide for this test. CMS has approved the use of such tests of reasonableness via our CMS approved SC Medicaid State Plan and has also approved the use of such mechanisms in other states.**

- **After reviewing additional documentation, and based in part upon the commenters' requests, the Medicaid Agency has revised its scope of service changes policy as reflected on the attached schedule. Additionally, the Medicaid Agency will not settle on using projected cost and**

encounter data solely to estimate the amount of the encounter rate change associated with the scope of service change. It would be irresponsible for the Medicaid Agency to not use actual cost and apply the results retroactively.

- **The Medicaid Agency will ensure that SC Medicaid MCOs are reimbursing FQHCs at a minimum 100% of the APM PPS rate effective for services beginning on and after July 1, 2016. This analysis will be performed on a quarterly basis and will be reflected within the state plan amendment. Additionally, The Medicaid Agency will WRAP scope of service rate changes for SC Medicaid MCO enrollees until the rate has been built into the SC Medicaid MCO rates.**

- **The April 26, 2016 State Medicaid Director letter allows the SC Medicaid Agency to proceed with its July 1, 2016 FQHC payment methodology.**

- **Out of network service payment issues have been resolved and any FQHC service provided must be paid at 100% of the July 1, 2016 APM PPS rate. Also when a procedure is performed in a FQHC and the fee for service reimbursement is greater than the FQHC encounter rate, the CPT procedure code should be paid.**

"Comment 1: The proposed notice states that an addition or deletion of SC Medicaid covered specialty and non-primary services that were either included (deletion) or not included (addition) in the baseline PPS rate or APM/PPS rate calculation. The FQHC reimbursement rate applies to a larger set of services than "SC Medicaid covered specialty and non-primary services". The FQHC reimbursement rate must include the cost of both "FQHC Services" and "any other ambulatory services" included in the State's plan. SSA § 1905(a)(2)(C).

Comment 2: The Department should respond to a FQHC request for change in scope within thirty (30) days of receiving the information necessary to effect a FQHC change-in-scope request.

Comment 3: In making any initial or subsequent reimbursement determinations for any FQHC, the Department should not take into account or consider (deduct?) managed care financial incentive payments or other income, however defined, received by the FQHC, including but not limited to 330 federal funding as well as any other federal, state and/or private funding sources.

Comment 4: Suggested Methodology for determining CIS (Change in Scope of Services) for Centers with PPS reimbursement model:

A. Professional Services

1. Dentists

2. Chiropractors

3. Optometrists

4. Behavioral Health

Comment 5: Ambulatory/Ancillary Services: All ambulatory or ancillary services in the state Medicaid plan (other than those identified medical and/or behavioral professional services as defined above) shall be paid based on the average of the actual costs of the Center for providing such serves in 1999 and 2000 using a FQHC specialized FFS schedule updated by the MEI and any change in scope of services associated with implementation of the new service. The fee schedules amounts shall be determined by adjusting the 1999 and 2000 Medicaid FFS schedule to reflect 100% of the actual costs to the Center for the services

represented by the CPT codes used in 1999 and 2000 by the Department, trended forward by the MEI. A new "specialized fee schedule for FQHCs and RHCs shall be developed". i.e., (the FQHC/RHC FFS Schedule). The FQHC/RHC FFS schedule shall include all services represented by CPT codes in the current Medicaid fee schedule – (1999 and 2000 fee schedules brought forward together with change in scope for capital expenses as requested by a Center). Examples of services that the specialized FQHC FFS system shall include are ambulatory/ancillary services in the approved state Medicaid plan, including but not limited to the following:

a. Transportation

b. Long-term care

c. Nursing Facility services and home health care

d. Laboratory and outpatient diagnostic services

e. Pediatric and family nurse services

f. Preventive child-care services (screening, immunizations, physical exams, etc. for persons under age 21)

g. Pregnancy Services.

h. Prescription drugs. (average of formulas for 1999 and 2000 brought forward by MEI determined by the following formula)

Example: Average for 1999 and 2000 = ((AWP – 10%) + MEI trended forward by dispensing MEI)) + $4.05 trended forward by dispensing MEI. (Because it is a formula, it will work for any NDC Code).

i. Rehabilitation and physical rehabilitation.

J. DME

Comment 6: Miscellaneous matters relating to Ambulatory (ancillary) services and the (Change in Scope of Services) CIS process. CIS is defined as the addition of a new FQHC or RHC service in the approved state Medicaid plan that is not incorporated in a Center's baseline prospective payment system (PPS) rate, or a deletion of an FQHC or RHC service that is incorporated in the baseline PPS rate. FQHCs shall be responsible for informing the Department, in writing, when reimbursement for a CIS is needed for services not reflected on the fee schedule. The Department shall provide the forms and information required to be provided with the CIS. CIS' include but are not limited to:

i. A Change in service due to a federal amended regulatory requirements or rules.

ii. A change in service resulting from relocating or remodeling an FQHC or RHC.

iii. A change in types of service(s) due to a change in applicable technology and medical practice utilized by the center or clinic.

iv. An increase in service intensity attributable to changes in the types of patients served, including, but not limited to ,populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

v. Any changes in the services and/or provider mix of an FQHC or RHC or one of its' sites.

vi. Any changes in operating costs attributable to capital expenditures associated with expanded service and/or administrative facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

vii. Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents.

viii. Any changes in the scope of a project approved by the federal Health Resources and Service Administration (HRSA), the Medicare Program, the Child Health and Disability Prevention (CHDP) program, the Children's Health Insurance Program and/or any other medical assistance program in which the state of South Carolina participates. For a HRSA approved CIS, the Center shall provide a copy of the HRSA approval letter to Medicaid, which shall be sufficient for approval of the CIS.

ix. DHHS shall have no more than 90 days after the Center has provided the HRSA approval and/or supporting documentation required by the Department to establish the Center's new or revised baseline PPS reimbursement rate. The new or revised baseline PPS reimbursement rate shall be retroactive to the date the CIS is approved by HRSA. For all other CIS', the CIS' effective date shall be the date the CIS is received by the Department.

x. In the event the Department does not notify the Center, in writing, of the reimbursement determination within the 90 day period following receipt of the documentation provided by the Center, the Department shall adjust the PPS reimbursement rate of the Center by the rate increase or decrease proposed by the Center for the CIS, and the reimbursement rate request submitted by the Center shall become final. Regardless, at the Center's and/or the Department's request, the CIS reimbursement amount may be reevaluated at the end of 24 months from the first day the CIS was effective. A request for reevaluation of the reimbursement associated with a CIS request must be made within 90 days following the end of the second fiscal year in which a reimbursement change occurred. In the event the Department does not notify the Center, in writing, of the reimbursement redetermination within 90 days following receipt of requested documentation provided by the Center, the Department shall adjust the PPS reimbursement rate of the Center by the rate increase or decrease proposed by the Center, and the revised rate shall become final. The Department or the Center may request an audit of the information used to determine the CIS change in reimbursement at the end of twelve (12) or twenty-four (24) months following the effective date of the CIS to validated the Center's allowable costs and visits. The cost of the audit shall be borne by the Department. The Department shall balance the funds that should have been reimbursed by the audited Center against the funds actually received by the audited Center, and make any necessary settlements or recoupments.

xi. CCI Edits – Reimbursement for CPT codes in effect in 1999 and 2000 (as determined by the specialized "FQHC reimbursement schedule noted above] remain the same for the underlying services addressed by bundling of several CPT codes into one CPT code as a result of CCI edits.

xii. Diagnosis coding policies for all Medicaid provided services shall be no more restrictive for FQHCs and RHC claims (professional or otherwise) than the restrictions that were in effect on January 1, 2001.

xiii. Such other and further services allowed by law.

Comment 7: The Department shall require all MCOs to utilize the specialized FQHC fee schedule for FQHC services provided to Medicaid beneficiaries. The Department shall require all MCOs to provide information for professional services, for services reimbursed to the FQHC FFS schedule to DHHS as well as for services reimbursed in all other manners to allow proper calculation of quarterly wrap payments to each Center.

Comment 8: The Department shall establish a mechanism for FQHCs to provide for continuous skilled nursing care to persons in the need of such care as a Medicaid reimbursed FQHC benefit. “Continuous skilled nursing care” means medically necessary care provided by, or under the supervision of a R.N., L.P.N., or Therapist (such as nursing care, physical, occupational, speech, respiratory therapies, social services and hospice care) within his or her scope of practice, seven days a week, 24 hours per day, in facilities participating in the program, including hospice centers and licensed nursing homes, or in a beneficiary’s home.

Comment 9: The Department shall establish a mechanism for FQHCs to provide for continuous skilled at home nursing care to persons in the need of such care as a Medicaid reimbursed FQHC benefit. “Skilled at home nursing care” means medically necessary care provided by, or under the supervision of a R.N., L.P.N., or Therapist (such as nursing care, physical, occupational, speech, respiratory therapies, social services and hospice care) within his or her scope of practice at the patient’s place or residence for the elderly, new and expectant parents, individuals with disabilities, and those transitioning from a hospital or other medical facility to home.

Comment 10: The Department shall establish a program to provide non-skilled home nursing care to persons in the need of such care as a benefit of the state Medicaid plan program as a Medicaid FQHC reimbursed benefit for the elderly, new and expectant parents, individuals with disabilities, and those transitioning from a hospital or medical facility to home. Non-skilled care may be delivered by Home Health Aides (HHAs) or Certified Nursing Assistants (CNAs) employed by a FQHC to assist with such personal care activities as bathing, grooming, dressing, as well as assistance with meal preparation, light housekeeping, medication reminders, assistance with ambulation, and transportation to medical appointments.

Comment: 11: In the event a CPT code from the Medicaid fee schedule exceeds the specialized FQHC fee schedule, the higher reimbursement applies.

Comment 12: The Medicare Chronic Care Management (CCM) service shall be reimbursed at 100% of the cost of the Center providing such service.

Comment 13: The Medicare Advance Care Planning (ACP) should be afforded as a Medicaid benefit service as stand-alone billable face-to-face visits providable by any FQHC/RHC professional as well as RNs and LPNs.

Comment 14: For services under the approved state Medicaid plan that are paid on a “cost-basis” (that are not “E/M professional codes” nor paid pursuant to the FQHC/RHC specialized FFS reimbursement schedule) shal be evaluated as a separate service aprt from the PPS for each Center that adds the service to determine that the Center is reimbursed 100% of actual costs for delivery of service. Once cost rate is established, evaluate yearly to insure that Center receives no less than the greater of:

(i) Original baseline rate plus MEI increase(s), or

(ii) reasonable costs for year at issue.

Comment 15: DME policies and reimbursement: Apply same Medicaid policies in existence as of January 1, 2001 unless increased by General Assembly or CMS. DME reimbursement to follow revised FQHC/RHC FFS schedule.

Comment 16: Allow social workers employed by FQHCs to provide case management enabling assistance services [as opposed to behavioral health services] to Medicaid beneficiaries, billable by the FQHC as a billable FQHC encounter.

Comment 17: The Department should reimburse FQHCs' for comprehensive perinatal services when provided by a comprehensive perinatal services Practitioner.

Comment 18: The Department should reimburse FQHCs' for Adult Day Health Care (ADHC) services when an FQHC providing the ADHC services has received approval from the Health Resources and Services Administration (HRSA) to provide ADHC services to the extent required by law. ADHC services are included in the State Plan.

Comment 19: The Department should reimburse FQHCs' for adding such services as Benefit Bank, social services, care coordination, medication management-all add to the amount [intensity] of services provided within the context of the office visit.

Comment 20: The Center may appeal the results of any final determination of the Department by filing an appeal with the Department's Division of Hearing and Appeals in accordance with S.C. Regulation 126-150 et. seq."

SCDHHS Responses:

- **Comment #1 – The Department provides for payment of a number of services outside of the FQHC encounter rate and these services are reimbursed separately via SC Medicaid fee schedules. Services reimbursed via fee schedules and not covered by the encounter rate are not subject to quarterly WRAP payment processes.**

- **Comment #2 – The Department agrees with the comment made and will review the scope of service change request within 30 days of receipt of the request.**

- **Comment #3 – The Department agrees and will not consider any revenue offsets received from grants, managed care financial incentive payments, etc. when reviewing scope of service changes.**

- **Comment #4 – The Department has revised its definition of events that would constitute a scope of service change for reimbursement purposes and can be identified as Attachment A. The Department has also published its "WRAP Payment Methodology" document identified as Attachment B which outlines which CPT codes can be billed as an encounter, which CPT codes are not covered by the encounter rate but are billed outside of the encounter rate and are reimbursed via SC Medicaid fee schedules. All other CPT codes not identified in sections 1, 2, and 3 are considered to be covered by the SC Medicaid FQHC encounter rate and are not separately billable.**

- **Comment #5 - The Department does not agree with the commenter's position and will continue to reimburse for services not covered by the FQHC encounter rate using SC Medicaid fee schedules.**

- **Comment #6 – See response to comment #4.**

- **Comment #7 – The Department does not agree with the commenter's position and the SC Medicaid contracting MCOs will continue to reimburse for services not covered by the FQHC encounter rate using their established fee schedule rates. Services reimbursed via fee schedules and not covered by the encounter rate are not subject to quarterly WRAP payment processes.**

- **Comment #8 – The Department does not agree with the commenter's position. Continuous skilled nursing care shall be the responsibility of the appropriate provider type (e.g. nursing facility, hospice centers, and home health agencies) and not the responsibility of the FQHC.**

- **Comment #9 – See Department response to comment #8.**

- **Comment #10 - See Department response to comment #8.**

- **Comment #11 – The Department does not agree with the commenter's position – see response to comment #5.**

- **Comment #12 – The Department does not agree with the commenter's position on this issue but will consider the possible coverage of this code at a future date.**

- **Comment #13 - The Department does not agree with the commenter's position on this issue but will consider the possible coverage of this code at a future date.**

- **Comment #14 – The Department does not agree with the commenter's position.**

- **Comment #15 – The Department does not agree with the commenter's position and will continue to reimburse Durable Medical Equipment using SC Medicaid fee schedule rates in effect at the time the service was rendered.**

- **Comment #16 – The Department does not agree with the commenter's position.**

- **Comment #17 – OB services are a covered service under the SC Medicaid FQHC Program.**

- **Comment #18 – The Department does not agree with the commenter's position. Adult Day Health Care services shall be the responsibility of the provider type that actually provides the service and not the responsibility of the FQHC.**

- **Comment #19 – The Department does not agree with the commenter's position.**

- **Comment #20 – This public notice does not affect the appeal rights of any party.**