MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 14-48 Effective Date corrected to As Indicated instead of January 1, 2015

Distribution: Federally Qualified Health Centers, Medicaid Health Plans

Issued: December 1, 2014

Subject: Federally Qualified Health Centers Reimbursement Methodology

Effective: As Indicated

Programs Affected: Medicaid, Healthy Michigan Plan

Background

Federally Qualified Health Center (FQHC) reimbursement conforms to Section 1902(bb) of the Social Security Act (the Act). As set forth in Section 1902(bb), all FQHCs that provide services (defined in section 1905[a][2][C] of the Act) after January 1, 2001 are reimbursed under either a Prospective Payment System (PPS) or an Alternative Payment Methodology (APM) as selected by the FQHC for Medicaid and Healthy Michigan Plan beneficiaries.

PPS Reimbursement Methodology

An FQHC that is not reimbursed under an APM will have eligible encounters reconciled to the Medicaid PPS as described in the FQHC Chapter of the Medicaid Provider Manual. Under the PPS, an FQHC will be reimbursed on a per visit basis. The per visit payment was based on the average of the FQHCs reasonable costs of providing Medicaid Services during Fiscal Year (FY) 1999 and FY 2000. Reasonable costs are defined as the per visit amount approved by Medicare as of October 1, 2001, and then adjusted to reflect the cost of providing services to Medicaid beneficiaries that are not covered by Medicare. The baseline per visit amount is adjusted annually using the Medicare Economic Index (MEI) as designated in Section 1902(bb)(3)(A).

In compliance with an approved State Plan Amendment, effective for dates of service on or after January 1, 2014, FQHCs providing selected procedures in the FQHC setting will be reimbursed pursuant to the payment methodology described under Attachment 4.19-B, Individual Practitioner Services, of the Michigan Medicaid State Plan. The following procedures will not be subject to the PPS per visit amount:

- Endometrial ablation, thermal, without hysteroscopic guidance;
- Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed;
- Hysteroscopy with endometrial ablation (e.g., endometrial resection, electrosurgical ablation, thermoablation); and
- Hysteroscopy with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants.

In addition, FQHCs administering specific vaccines and drugs in the FQHC setting will be reimbursed pursuant to the payment methodology described under Attachment 4.19-B, Individual Practitioner Services, of the Michigan Medicaid State Plan. The following vaccine and drugs that will not be subject to the PPS per visit amount include:

- Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use;
- Rho(D) immune globulin (Rhlg), human, full-dose, for intramuscular use;
- Human Papilloma Virus (HPV) vaccine, types 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use (applicable to adult beneficiaries age 19 years and over only); and
- Physician administered drugs, including chemotherapy drugs (commonly referred to as J-Codes).

These services can be billed in conjunction with an allowable FQHC encounter. Refer to the FQHC Chapter of the Michigan Medicaid Provider Manual for additional information regarding PPS reimbursement.

Alternative Payment Methodology

In compliance with an approved State Plan Amendment, effective for dates of service on or after January 1, 2014, FQHCs may agree in writing, through a Memorandum of Agreement (MOA) to be reimbursed under the APM as described in Attachment 4.19-B, Federally Qualified Health Center Services, subsection B of the Michigan Medicaid State Plan.

For FQHCs providing dental care, an amount to be specified in the MOA will be added on to a dental encounter that includes restorative services, endodontics, or extractions to account for the additional costs associated with these non-preventive procedures. The per visit add-on amount will be adjusted annually using the MEI. For an FQHC paid under the APM, the PPS base methodology will be maintained to ensure compliance with Section 1902(bb)(6)(B) of the Act.

MOAs will be distributed to all FQHCs for review and signature. Once the signature process is complete, the MOA must be mailed back to the address provided with the MOA. The signed agreement does not supersede any corresponding policy in the Michigan Medicaid Provider Manual, but documents the clinics' acceptance of the terms outlined in the Michigan Medicaid State Plan. The MDCH Hospital and Clinic Reimbursement Division (HCRD) will retain a copy of the signed MOA in their files. If an FQHC does not sign the MOA, reimbursement defaults to that which is described in the PPS base rate methodology of the Act. Newly created FQHCs will be permitted to choose between the PPS or APM during the rate setting process.

FQHC providers are expected to practice in accordance with the accepted standards of care and professional guidelines applicable to medical, dental, and behavioral health services, and comply with all applicable policies published in the Michigan Medicaid Provider Manual. Inappropriate payments identified in post-payment review are subject to recoupment. The FQHC has the full responsibility to maintain proper and complete documentation to verify the services provided.

Allowable Places of Service

Services provided to beneficiaries within the four walls of the FQHC and approved FQHC satellites are allowable for reimbursement under the PPS or the APM. Off-site services provided by employed practitioners of the FQHC to patients temporarily homebound or in any assisted living or skilled nursing facility because of a medical condition that prevents the patient from traveling to the FQHC are also allowable for reimbursement under the PPS or the APM.

If a practitioner employed by an FQHC provides services at an inpatient hospital, the service must be billed under the individual practitioner’s Medicaid provider number and will be reimbursed the appropriate fee screen rate. Services performed in an inpatient hospital setting are not included under the PPS or APM. The costs that are associated with these services must be excluded from the FQHCs Medicaid Reconciliation Report.

Notification of Changes

FQHCs are required to notify the HCRD in writing within seven (7) business days of any of the following changes:

- Health Resources and Services Administration (HRSA) notification of lost FQHC status; or
- Opening(s) and/or closing(s) of any HRSA approved satellite/mobile center(s) sites.

Manual Maintenance

Retain this bulletin until the information is incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Stephen Fitton, Director
Medical Services Administration