PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

CITATION
Section 1902(aa) of Social Security Act

Medical and Remedial Care and Services
Item 2.b.

Rural Health Clinic Services and Other Ambulatory Services Provided by a Rural Health Clinic

I. **Method of Payment**

In accordance with Section 1902(aa)/the provisions of the Benefits Improvement Act (BIPA) of 2000, effective January 1, 2001 payments to Rural Health Clinics (RHCs) for Medicaid covered services will be made under a Prospective Payment System (PPS) and paid on a per visit basis.

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HCFA 179 LA-01-02
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The PPS per visit rate will be provider specific. To establish the baseline rate for 2001, each RHC's 1999 and 2000 allowable costs, as taken from the RHC's filed 1999 and 2000 Medicaid cost reports, will be totaled and divided by the total number of Medicaid patient visits for 1999 and 2000. A patient visit is defined as receipt of services from a licensed practitioner and includes doctors, dentists, psychologists, social workers, nurse practitioners and physicians' assistants.

For RHCs beginning operation in 2000 and having only a 2000 cost report available for determining the initial PPS per visit rate, the 2000 allowable costs will be divided by the total number of Medicaid patient visits for 2000. Upon receipt of the 2001 cost report, the rate methodology will be applied using 2000 and 2001 costs and Medicaid patient visits to determine a new rate.

Upon receipt of the final audited cost reports for 1999 and 2000, the rate will be recalculated using costs and Medicaid patient visits from those reports. Payments will be reconciled against the initial PPS per visit rate, with recoupments and lump sum payments issued in accordance with existing State processes for cost report settlement.

SUPERSEDES: TN- LA - 96-05

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The baseline calculation will include all Medicaid coverable services provided by the RHC regardless of existing methods of reimbursement for said services. This will include, but not be limited to, ambulatory, transportation, laboratory (where applicable), KidMed and dental services previously reimbursed on a fee-for-service or other non-encounter basis. The per visit rate will be all inclusive-RHCs will not be eligible to bill separately for any Medicaid covered services. RHCs will be responsible for maintaining licensure/accreditation/program participation standards for all such services. In the event an RHC does not currently participate in any such program, but wishes to begin participation, the RHC will be responsible for meeting all enrollment criteria of the program.

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For the purpose of the calculation methodology, fiscal year is defined as the fiscal year of the participating RHC. Beginning with 2001, RHCs will be responsible for submission of their annual cost report for the year ending on June 30.

RHCs will be responsible for apportioning patient visits and statistical data in their 2001 cost report. The apportionment will be for the period from the first day of the 2001 cost reporting period through December 31, 2000. This data will be used to calculate cost settlements due from/to providers for the final cost-based reimbursement period in calendar year 2000. Note: Providers with a 12/31 fiscal year end do not have to conduct this apportionment.

Upon completion and implementation of PPS rate determination, the State will reconcile payments back to January 1, 2001. This will be accomplished by calculating a payment amount for eligible patient visits under PPS and comparing it to payments made for encounters under the existing cost-based reimbursement methodology.

SUPERSEDES: NONE - NEW PAGE

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CITATION	
42 CFR 447.201 and	Medical and Remedial Care and Services
Section 1902(bb) of the Social Security Act	Item 2.b.

No interim or alternate payment methodologies will be developed by the State without prior notification to each enrolled Medicaid RHC.

Should an RHC increase or decrease its scope of services through new program development, program closure, program enhancement, etc., it is responsible for notifying the Bureau of Health Services Financing, Institutional Reimbursements Section of the scope of change in writing. The RHC shall include with this notification a budgetary presentation showing the impact on costs and Medicaid patient visits. The Institutional Reimbursements Section will be responsible for incorporating allowable costs and visits into the PPS per visit rate calculation and determining a new rate.

For an RHC which enrolls and receives approval to operate on or after January 1, 2001, the facility's initial PPS per visit rate will be determined first through comparison to other RHCs in the same town/city/parish. Scope of services will be considered in determining which proximate RHC most closely approximates the new provider. If no RHCs are available in the proximity, comparison will be made to the nearest RHC offering the same scope of services. The rate will be set to that of the RHC comparative to the new provider.

Beginning with Federal fiscal year 2002, the PPS per visit rate for each facility will be increased annually by the percentage increase in the published Medicare Economic Index (MEI) for primary care services. The MEI increase will be applied on July 1 of each year.

Effective for dates of services on or after February 21, 2011, the Medicaid Program shall provide reimbursement for diabetes self-management training (DSMT) services rendered by qualified health care professionals in the RHC encounter rate. Separate encounters for DSMT services are not permitted and the delivery of DSMT services alone does not constitute an encounter visit.

Alternative Payment Methodology

Adjunct Services

Effective for dates of service on or after October 21, 2007, the Medicaid Program shall provide for an alternate payment methodology. This alternate methodology will include the aforementioned PPS methodology plus an additional reimbursement for adjunct services provided by rural health clinics when these services are rendered during evening, weekend or holiday hours. Reimbursement is limited to services rendered between the hours of 5 p.m. and 8 a.m. Monday through Friday, on weekends and State legal holidays. (NOTE: A payment for adjunct services is not allowed when the encounter is for dental services only).

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The reimbursement for adjunct services is a flat fee, based on the adjunct CPT code(s) regardless of practitioner (except for dental), in addition to the reimbursement for the associated office encounter (PPS methodology). The agency's rates for the adjunct services add-on are on the Professional Services Fee Schedule and are effective for services provided on or after October 21, 2007. The same add-on rate for services delivered between the hours of 5pm and 8am on Monday through Friday, on weekends, and State legal holidays is paid to governmental and non-governmental providers.

The Alternative Payment Methodology (APM) will be agreed to by the Department and the RHC, and will result in payment to the RHC of an amount that is at least equal to the Prospective Payment System (PPS) rate.

Long-Acting Reversible Contraceptives

Effective for dates of service on or after January 1, 2019, RHCs shall be reimbursed a separate payment outside of the PPS rate, accordingly, for long-acting reversible contraceptives (LARCs). This alternate methodology will include the PPS rate, plus reimbursement for the device.

Reimbursement for LARCs shall be at the lesser of, the rate on file or the actual acquisition cost, for entities participating in the 340B program. RHCs eligible for 340B pricing must bill Medicaid at their 340B actual acquisition cost for reimbursement.

Behavioral Health and Dental Services

Effective for dates of service on or after April 1, 2019, the Medicaid Program shall establish an alternative payment methodology for behavioral health services provided in RHCs by one of the following practitioners:

1. Physicians with a psychiatric specialty;
2. Nurse practitioners or clinical nurse specialist with a psychiatric specialty;
3. Licensed clinical social workers; or
4. Clinical psychologists.

The reimbursement for behavioral health services will equal the all-inclusive encounter PPS rate on file for fee-for-service on the date of service. This reimbursement will be in addition to any all-inclusive PPS rate on the same date for a medical/dental visit.

Dental services shall be reimbursed at the all-inclusive PPS rate on file for fee-for-service on the date of service. This reimbursement will be in addition to any all-inclusive PPS rate made on the same date for a medical/behavioral health visit.

The Alternative Payment Methodology (APM) will be agreed to by the Department and the RHC, and will result in payment to the RHC of an amount that is at least equal to the Prospective Payment System (PPS) rate.

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Alternative Payment Methodology for Rural Health Clinics that are licensed as part of a small rural hospital defined in Attachment 4.19-A, Item 1

Effective for dates of service on or after July 1, 2008, Rural Health Clinics (RHCs) as defined in Attachment 4.19-A Item 1 may elect to be reimbursed under this Alternative Payment Methodology (APM). The RHCs that are licensed as part of a small rural hospital as of July 1, 2007, shall be reimbursed no less than, in the aggregate, 110 percent of allowable costs.

Interim payment for claims shall be the Medicaid PPS per visit rate for each provider. Final reimbursement shall be the greater of the BIPA PPS and the APM of 110 percent of allowable cost as calculated through the cost settlement process.

The payment received under this methodology will be compared each year to the BIPA PPS rate to ensure that the payment methodology under this APM is at least equal to the BIPA PPS rate. If the payment calculation at 110 percent of allowable cost is less than the BIPA PPS rate, the RHC will be paid the difference.

Effective for dates of service on or after July 1, 2023, the reimbursement methodology for services rendered by a RHC licensed as part of a small rural hospital and included as a hospital outpatient department on the hospital's fiscal year end cost report prior to July 1, 2023, shall be eligible for the APM at 110 percent of allowable costs as calculated through cost settlement, as follows:

1. Future qualifications for the 110 percent APM reimbursement shall be determined by the Louisiana Department of Health on an annual basis for hospital-based rural health clinics enrolling and licensing as hospital outpatient departments during the hospital's fiscal year end cost reporting periods subsequent to June 30, 2023. Payments shall begin effective for dates of service beginning on July 1 of the year subsequent to qualification.

2. Hospital-based rural health clinics that terminate their licensing as hospital outpatient departments will no longer be eligible for the APM at 110 percent of allowable costs upon the effective date of the termination.

Managed Care Enrollees

An RHC that furnishes services that qualify as an encounter to Medicaid beneficiaries pursuant to a contract with a managed care entity, as defined in Section 1932(a)(1)(B) of the Social Security Act, where the payment(s) from such entity is less than the amount the RHC would be entitled to receive under PPS or APM, will be eligible to receive a wrap-around supplemental payment processed and paid by Louisiana Department of Health. The wrap-around supplemental payment shall be made no less frequently than every four months and reconciled no less than annually. Payments related to yearly reconciliations will be made within the two year payment requirements at 42 CFR Section 447.45 and 45 CFR Section 95, Subpart A.

Standards for Payment

To be eligible for reimbursement, a rural health clinic must be located in a rural area and located in a U.S. Department of Health and Human Services designated health shortage area (an area having either a shortage of personal health services or a shortage of primary medical care manpower). It must be certified for participation in Medicare, Title XVIII and, therefore, deemed to meet the standards for certification under Louisiana's Medicaid program.

Community Health Worker Services

Effective for dates of service on or after January 1, 2022, Medicaid community health worker services provided by a RHC shall be reimbursed through an alternative payment methodology when these services are provided on the same date as a medical/dental/behavioral health visit. Community health workers are unlicensed providers that render preventive and other health services to beneficiaries. The APM will pay RHCs an add-on amount, equivalent to the fee schedule rate for the community health worker service, in addition to the PPS. The fee schedule rate for community health worker services is located at Provider Based Rural Health Clinics (PB-RHCs) Rates (Provider Type 79) https://www.lamedicaid.com.

The APM must be agreed to by the Department and the RHC, and must result in payment to the RHC which is at least the PPS rate on file for the date of service.