Division of Medical Assistance Programs (DMAP)

Medicaid & Rural Health Clinics

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AGENDA

- Prospective Payment System
- Change in Scope
- Billing Issues – Top Three
PROSPECTIVE PAYMENT SYSTEM
Prospective Payment System

- The Prospective Payment System became effective January 1, 2001
- 42 United State Code § 1396a(bb)
Prospective Payment System

- State plan shall provide for payment for Medicaid-covered services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average cost for furnishing such services during fiscal years 1999 and 2000
Prospective Payment System

- In general, a clinic’s PPS rate is calculated by dividing total clinic costs by total visits.
- The PPS rate is also referred to as an “all-inclusive” or “encounter” rate.
Prospective Payment System

- The initial PPS rate calculation is referred to as the baseline PPS rate.
Prospective Payment System

- Requires that a change in the rate under the PPS methodology can only be based on:
  1. The Medicare Economic Index (MEI) applied annually to adjust the rate for inflation, and
  2. A change in the scope of services
Prospective Payment System

- A clinic’s rate of reimbursement is prospective in that:
  - The Medicaid payment a provider is reimbursed in the future is predetermined based on the prior calculated baseline PPS rate
  - Reimbursement is the baseline PPS rate adjusted by the MEI January 1 of each year
Prospective Payment System

- Prohibits rebasing of the PPS baseline rate unless included under an Alternate Payment Methodology, requiring a State Plan Amendment approved by the Centers for Medicaid & Medicare Services (CMS)
Prospective Payment System

- Alternate Payment Methodology (APM), at a minimum:
  - Agreed to by the State and all clinics
  - Results in payment of an amount which is at least equal to the amount required under PPS
Prospective Payment System

- Original federal legislation included a section requiring the Government Accountability Office (GAO) to review states’ implementation of the new PPS requirements and if there was a need to rebase or refine the PPS within 4 years from implementation of PPS (1-1-2001)
Prospective Payment System

- Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, sec. 702(d) “GAO STUDY OF FUTURE REBASING - The Comptroller General of the United States shall provide for a study on the need for, and how to, rebase or refine costs for making payment under the Medicaid program for services provided by ... rural health clinics... The Comptroller General shall provide for submittal of a report on such study to Congress by not later than 4 years after the date of the enactment of this Act.”
Prospective Payment System

- The June 2005 GAO study determined evidence to date is insufficient to determine the need to rebase or refine the PPS, although limitations were acknowledged. (GAO-05-452)
Prospective Payment System

- In response to the GAO study, CMS concluded there is currently no evidence or data to reflect that a need for a revised inflation factor is warranted at this time.
Prospective Payment System

Therefore, federal legislation does not allow for DMAP to re-base a health center’s PPS rate. Or, DMAP is prohibited from calculating a new baseline PPS rate based on a clinic’s current costs.
Prospective Payment System

- DMAP can *adjust* a health center’s PPS rate to account for any increase or decrease in the scope of services and costs specific to the change(s).
CHANGE IN SCOPE
Change in Scope

- A change in the ‘scope of services’ is defined by the Centers for Medicare and Medicaid Services (CMS) as a change in the type, intensity, duration and/or amount of services.
Change in Scope

- CMS does not define "type," "intensity," and "duration" for State Medicaid agencies
- CMS provides a broad definition of change in scope of services to allow states the flexibility to develop more precise procedures for this provision
Change in Scope

- Oregon Administrative Rule (OAR) 410-147-0362 Change in Scope of Services became effective October 1, 2008
Change in Scope

- As required by Federal law, DMAP is required to adjust a RHC’s Prospective Payment System (PPS) encounter rate based a qualifying increase or decrease in the scope of RHC services.
Change in Scope

- To date, no RHC has requested a change in scope.
Change in Scope

- A change in the cost of a service is not considered in and of itself a change in the scope of services.
Change in Scope

- An RHC must demonstrate how a change in the scope of services impacts the overall picture of health center services.
Change in Scope

- To qualify for a rate adjustment, changes must result in a minimum 5% change in cost per visit.
- Health centers may submit a maximum of one change in scope application per year.
Change in Scope Examples

- Addition of services (e.g. dental, mental health, internal medicine, laboratory and/or radiology)
- Think of services you may have referred out at one time, that are now performed in the clinic
- Are new costs incurred?
Change in Scope Examples

- Change in applicable technologies or medical practices?
- DMAP will include maintenance (not one-time start up) costs:
  - Update a practice management system
  - New electronic health records
TOP THREE BILLING ISSUES
Billing Issues – #3

3. Continued billing for treatment of a below the line diagnoses.
Billing Issues - #3

- The Division covers reasonable services for diagnosing conditions, including the initial diagnosis of a condition that is below the funding line on the Health Service Commission’s List of Prioritized Services (HSC List).
Billing Issues - #3

- Once a diagnosis is established for a service, treatment or item that falls below the funding line, the Division will not cover any other services related to the diagnosis.
Examples of below the line diagnosis (range from 3 services in a week to 11 services over 3 months) include:

- 724.2 Lumbago (general lower back pain) & 724.5 Backache, unspecified
- 692.9 Dermatitis, unspecified cause
- 465.9 Acute respiratory infection unspecified site
Billing Issues - #3

- For example, OHP does not pay for the following services:
  - **Treatment** for conditions that get better on their own (such as colds or flu)
  - **Treatment** for conditions for which home treatment works (such as sprains, allergies, corns, calluses or some skin conditions)
Billing Issues – #2

2. Duplicate billing – Processing payment for each:
   ▪ UB 04 institution claim form received directly from Medicare
   ▪ Professional claim format received directly from the provider:
     ● 837P electronic claim
     ● DMAP 505 paper claim
     ● Professional claim via the provider web portal
Billing Issues – #1

1. Under billing – billing at less than Rural Health Clinic’s Prospective Payment System (PPS) all-inclusive encounter rate
Billing Issues – #1

1. Under billing – Appears billing systems may not be updated with the new PPS rate adjusted by the Medicare Economic Index January 1 each year.
Billing Issues – #1

- Primary under billed services:
  - 90471 – immunization administration
  - 99211 – office visit, “nurse only”
  - 96372 – Therapeutic prophylactic, or diagnostic injection
Where to Get More Information

- Refer to the DMAP Provider Contacts booklet
- Questions about RHC program policy? Can’t get an answer to your question?
  - Call or email the RHC Program Manager,
    Daneka.Karma@state.or.us (503) 945-6926