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.

Billing Issues - #3

- 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