

**Federally Qualified Health Center (FQHC) / Rural Health Clinic (RHC)
Prospective Payment System (PPS) Frequently Asked Questions**

General

1. Is there language in our agreement around updated contracts with the FQHCs that I can reference?

2015 Physical Health HealthChoices Agreement Language:

Section VII.E.5 - Payments to FQHCs and Rural Health Centers (RHCs)

Effective with dates of services beginning on or after January 1, 2016, the PH-MCO must pay all FQHCs and RHCs rates that are not less than the Fee-for-Service Prospective Payment System (PPS) rate(s), as determined by the Department. The PH-MCO must also include in its Provider Network every FQHC and RHC located within this HealthChoices Zone that is willing to accept PPS rates as payment in full.

Section II-7. D. 1 (PSR) Behavioral Health (BH) HealthChoices Agreement Language:

Effective January 1, 2016, the Primary Contractor must provide Members access to FQHCs and RHCs within the Provider Network. The Primary Contractor must pay FQHC and RHC rates no less than Fee-for-Service Prospective Payment System (PPS) rates, as determined by the Department. The Primary Contractor must include in its Provider Network every FQHC and RHC that is willing to accept PPS rates as payment in full

2. If effective 1/1/16, will this be included in the 2016 HealthChoices Agreement?

Yes, paying the PPS rate to the FQHC/RHCs was included in the last Amendment to the HealthChoices Agreement. Please see the response to #1 above.

3. Are there any services payable to FQHC/RHC that are not considered “encounters”?

Yes. Healthy Beginnings Plus (HBP) visits are not considered to be encounters.

4. If a service is provided but does not meet encounter definition cited in the provider manual and FQHC/RHC bills for those services without the T1015 encounter code, are ANY of those services payable?

No. The PPS is an all-inclusive rate for services provided (except HBP services).

5. Aside from Health Beginnings Plus if enrolled which is paid at HBP fee schedule, are there any other services payable to an FQHC?

Remember that PPS is an all-inclusive rate for services provided. However, incentives and bonuses are payable outside the PPS rate.

6. If a member comes in for a flu shot or pneumonia vaccine to RHC and that service alone, and the RHC bills the flu or pneumonia vaccine to the Managed Care Plans without the T1015, is that service payable to the RHC?

No, administration of these vaccines alone does not count as an encounter separately for RHCs.

7. If we pay for services other than T1015 or HBP (Healthy Beginnings Plus) services to an FQHC/RHC will those encounters be accepted or rejected?

PROMISE will accept the encounter regardless. There is no edit on encounters for FQHC/RHC providers. However, the PPS is an all-inclusive rate for services provided. Other than HBP services all other services provided should be billed (if allowable) with T1015.

8. If we find a discrepancy between a rate letter from a provider and PROMISE, we should go with the rate letter?

Yes, as PROMISE is a prospective system, it will not properly capture the retrospective rate adjustment period. It often changes the PPS rate (or status of the rate – interim to regular), and that information is contained in the rate letters. The only way to 100% guarantee certain on your obligation is to get a copy of the rate letters from the FQHCs/RHCs. The Department also plans to notify you when a change is made to the PPS rate for one of your contracted FQHC/RHCs via email. The Department will also publish an update to the PPS rate list quarterly to ensure the MCOs have the most recent PPS rate available.

9. Are the MCOs responsible for retroactive claims adjustments due to a change in the PPS rate?

Yes, you will be responsible to make any rate adjustments back to January 1, 2016.

10. How does PROMISE handle payment of T1015 when third party insurance pays first?

For Medicare Crossover Claims: The MCOs may offset payment by the amount Medicare paid for T1015.

For Other Claims: The Department is still drafting a response.

11. What is the MCOs PPS obligation if the FQHC bills less than the PPS rate?

The MCO is required to pay 'at least the PPS rate' regardless of the billed amount submitted on the claim.

12. Will DHS be updating the PPS rate list on a routine basis? Will there be communication with the plans to let us know when updates occur?

Yes, the Department will issue an updated PPS rate list quarterly to the MCOs, and in the interim notify the MCOs when an FQHC/RHC in their network has a change in their rate occur.

13. Regarding multiple encounters per day, can the recipient get a physical health service and a behavioral health service in the same day because they are both Medical services?

FQHCs/RHCs may bill for more than one encounter (such as a medical encounter, and a dental and/or a behavioral health encounter) for the same patient on the same day. Additional other health encounters may be billed with the applicable type of service; however, medical necessity for the billing of such multiple encounters on the same day must be fully documented (including the time individually spent with the patient during each encounter) and justified in the patient's record. Medical necessity for multiple daily encounters is verified by periodic site audit, and must meet the federal standard mandated at 42 CFR §405.2463.

Please review page 11 of the FQHC/RHC Provider Handbook for circumstances where this does not apply.

14. Is there a list of FQHC/RHC's that are certified by DHS as medical suppliers?

The Department is not aware of any FQHC/RHCs enrolled as a Medical Supplier. However, Medical Suppliers are registered with the Department of Health (DOH) in accordance with DOH regulations in Chapter 25, Controlled Substances, Drugs, Devices and Cosmetics (receive a certificate of registration). Medical Suppliers must submit their DOH certificate of registration, with their MA Program Provider Enrollment Application, in order to be enrolled in the MA Program as a Medical Supplier (PT 25).

Please note the following from FQHC Provider Handbook (bottom of pg 11 and top of pg 12):

The following are NOT covered by Medical Assistance and do not constitute encounters under this definition: 1. Phlebotomy, specimen collections, laboratory tests, taking x-rays, filling/dispensing prescriptions, visits solely for the purpose of obtaining immunizations, allergy, or other injections, medication “pick ups” and/or providing durable medical equipment services (crutches, canes, braces, eyeglasses, hearing aids, and the like). Costs for these services and/or supplies and equipment may be included as reimbursable on the cost report, for inclusion in the encounter rate, if not directly provided by an independently enrolled entity associated with the FQHC/RHC. NOTE: FQHCs/RHCs that wish to dispense durable medical equipment must be certified as a medical supplier by the Pennsylvania Department of Health;

15. Can the MCOs make payments outside the PPS rate for things like EHR reporting and/or HEDIS measures?

The MCOs are allowed to pay incentives outside of the PPS rate. For example, the MCO has a provider incentive for electronic data that pays \$10 per diabetic patient when the provider can accurately submit needed chart data via EHR. This \$10 would be considered an incentive and would be paid in excess of the PPS rate.

Example – PPS rate \$100
EHR report \$10 incentive
Total payment \$110

Dental

16. Will the PPS rate apply to dental services provided at FQHCs and RHCs?

Yes. The MCOs are responsible to pay the PPS rate set for both Medical and Dental encounters. Dental encounters are billed using the code T1015/U9.

17. Are the Plans required to also utilize the T1015/U9 for implementation of the FQHC/RHC dental PPS payment?

Yes. The claims should be billed with U9 noted in the remarks section of the claim form.

18. Is use of T1015/U9 mandated for encounter data reporting purposes?

Yes. You should crosswalk the U9 in the remarks section to the modifier field on your encounter submission. For more detailed instructions on this, please contact PW_Encounter@pa.gov.

19. If applicable to dental services, will the parameters be similar to those outlined in MA Bulletin 08-10-50 “Dental Encounter Payment for Dental Services Rendered by Rural Health Clinics and Federally Qualified Health Centers”?

The Department is still drafting a response.

20. If a patient comes in for denture or partials adjustment and it was inserted less than 6 months should we bill our PPS rate for those visits?

The MCO is responsible for paying PPS rate for all encounters that happen on or after 1/1/2016. This requirement to pay PPS negates any prior arrangement for payment of services prior to 1/1/2016.

21. Is the PPS payment for FQHC dental encounters inclusive of all dental codes, or are there some dental services that are paid at PPS and some paid at FFS?

The PPS rate is an all-inclusive rate; this means all dental services provided by the FQHC/RHC are included in the provider specific dental PPS rate. This includes (but is not limited to) dentures and orthodontics. The FQHC/RHC should bill T1015/U9 (as noted above) for each time the member has a face-to-face dental encounter with an eligible dental practitioner (please refer to the Provider Handbook for more information on eligible dental encounters).

22. Can contractors have a listing of excluded services not included in the encounter rate?

No. The MCO is responsible for payment of all encounters eligible to be billed using T1015, which includes all services provided to the member in the FQHC/RHC.

For more information on what is defined as an ‘eligible encounter’, please refer to the FQHC/RHC Provider Handbook.

Behavioral Health

23. If a provider agrees to a FFS rate that is less than the PPS rate, are we allowed to contract with them at that agreed upon rate?

No. The minimum rate to be paid is the current PPS rate established by the Department.

24. Can the BH-MCO put limits on the amount of units per year for this service?

No. Services must be provided as long as they meet medical necessity criteria.

25. Must the BH-MCO adopt the FQHC FFS codes issued for Medicare FFS payments?

No.

26. Will the CMS codes be added to the Behavioral Health Services Reporting and Classification Chart (BHSRCC)?

There are no plans to add these codes to the BHSRCC at this time.

27. Given how CMS classifies the evaluation/therapies separate from the med checks, would we potentially need to pay for these as two separate encounters on the same day.

If the member receives multiple encounters in one day and the medical necessity for each is documented, then yes. Please see the response to #13 above for a more detailed response.

28. Do crisis services fall under the scope of prospective payment?

The PPS rate covers all costs to the FQHC/RHC as defined by their scope of services. If crisis intervention is part of their scope of services, then yes these services fall under the umbrella of the PPS rate.

29. How do I know if a specific provider location is to be paid PPS rate?

As long as the FQHC/RHC provider/service location appears on the PPS rate list issued by DHS to the BH-MCO, then that service location is to be paid the PPS rate. If a service location does not appear on this list, then the BH-MCO should consider them not approved to receive PPS payment at this location and your contracted rate would apply.

30. Are the MCOs required to add any willing RHC to the provider network as we do for FQHCs?

Yes, in accordance with the HC BH agreement language.

31. Can BH-MCOs continue to pay for mental health services using the T code provided the rate is commensurate with PPS?

The only code that the BH-MCO should pay on is T1015 with appropriate modifier. However, you may require the providers to bill all services provided to the BH-MCO when submitting their claim.

32. Are we required to manage FQHC/RHC services in adherence to the CMS Medicare PPS guidelines (especially with respect to minimum qualifications for mental health clinicians)?

No, you should utilize the DHS FQHC/RHC Provider Handbook for directive on how to pay PPS in Pennsylvania.

33. Does the PPS rate change in any way effect the minimum qualifications for people delivering Medicaid billable mental health services in FQHCs?

No. The list of eligible practitioners begins on page 9 of the FQHC/RHC Provider handbook. No other practitioners count as a completed medical encounter.

34. Would the state please clarify the minimum qualifications (allowable clinicians) who can provide and bill for BH services under HealthChoices?

The list of eligible practitioners begins on page 9 of the FQHC/RHC Provider handbook. Only those personnel count as an encounter. All other counselors or BH personnel do not qualify for eligible encounter billing.

35. Are we only permitted to pay the PPS rate for behavioral health encounters performed by a licensed clinical social worker (LCSW), doctoral level psychologist, psychiatric CRNP and psychiatrist, or will PPS payment be expanded to include services provided by LPCs and LMFTs?

Eligible encounters are billable for the practitioners that begin on page 9 of the FQHC/RHC Provider handbook. Currently, LPCs and LMFTs do not qualify as eligible to meet the medical encounter definition.

36. Are there documentation standards for services provided under T1015-HE?

Please see page 7 of the FQHC/RHC Provider Handbook for records requirements.

37. Should medication management visits be paid and reported under T1015-HE, or the two different codes classified as "Medical" within the CMS document (G0466 and G0467)?

All encounters should be billed using T1015 with the appropriate BH modifier. The BH-MCO may require additional services codes in billing. See the response to #31 above.

38. In addition to paying and reporting the established PPS rate under procedure code T1015-HE, will CMS codes G0469 (FQHC visit, mental health, new patient) and G0470 (FQHC visit, mental health, established patient) be added to the BHSRCC?

There are no plans to add these codes to the BHSRCC at this time.

39. Do you know if the BH-MCO's have any discretion to carve out services and pay differently for an FQHC if they are in agreement (while including the PPS on all other payments)?

No, all services provided by the FQHC/RHC are to be paid at the PPS rate.

40. Is there a minimum face-to-face time defined for a medical visit (e.g., psychiatrist) and/or for another health visit (e.g, LCSW)?

No, there is no timeframe associated with a clinic/encounter visit, T1015. An encounter is must only be a face-to-face encounter with an eligible practitioner.

41. Please confirm that all D&A treatment must be provided by DDAP-licensed personnel.

Yes, per state law any individual or facility providing D&A treatment to be licensed by DDAP. The only exceptions are physicians and licensed clinical psychologists who can provide treatment under their Dept of State license and scope of practice.

42. Are group sessions covered?

Yes, group sessions are allowable. Please refer to page 7 and 11 of the FQHC/RHC Provider Handbook.