

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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

CITATION

42 CFR
447.201 &
Section 1902(aa)
of the Social
Security Act

Medical and Remedial Care and Services
Item 2.c.

Federally Qualified Health Center Services

I. Reimbursement Methodology

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

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The PPS per visit rate will be provider specific. To establish the baseline rate for 2001, each FQHC's 1999 and 2000 allowable costs, as taken from the FQHC'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, psychologists, social worker, nurse practitioners and physician's assistants.

For FQHCs 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 96-22

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The baseline calculation will include all Medicaid coverable services provided by the FQHC 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-FQHCs will not be eligible to bill separately for any Medicaid covered services. FQHCs will be responsible for maintaining licensure/accreditation/program participation standards for all such services. In the event an FQHC does not currently participate in any such program, but wishes to begin participation, the FQHC 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 FQHC. Beginning with 2001, FQHCs will be responsible for submission of their annual cost report for the year ending on June 30.

FQHCs will be responsible 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: TN- LA 90-17

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

The FQHC is responsible for notifying the Bureau of Health Services Financing, Rate and Audit Review Section, in writing, of any increases or decreases in the scope of services as defined by the Bureau of Primary Health Care (BPHC) Policy Information Notice 2002-07. If the change is for inclusion of an additional service or deletion of an existing service, the FQHC shall include the following in this notification: the approval by BPHC, the current approved organization budget and a budget for the addition or deletion of services. The notice shall also include a presentation of the impact on total visits and Medicaid visits. A new interim rate will be established based upon the reasonable allowable cost contained in the budget information. Then a final PPS rate will be calculated using the first two years of audited cost reports which include the change in services.

If an FQHC receives approval for a satellite site, it must get a new Medicaid number for the satellite site, and the PPS per visit rate paid for the services performed at the satellite will be the weighted average cost payment rate per encounter for all FQHCs.

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For an FQHC 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 FQHCs in the same town/city/parish. Scope of services will be considered in determining which proximate FQHC most closely approximates the new provider. If no FQHCs are available in this proximity, comparison will be made to the nearest FQHC offering the same scope of services. The rate will be set to that of the FQHC comparative to the new provider.

For an FQHC which enrolls and receives approval to operate on or after October 21, 2004, the PPS per visit rate will be the statewide weighted average payment rate per encounter for all FQHCs.

Beginning with Federal fiscal year 2002, the PPS per visit rate for each facility will be increased annually by the percentage increase in the

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STATE	<u>Louisiana</u>	A
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published Medicare Economic Index (MEI) for primary care services. The MEI increase will be applied on July 1 of each year.

Effective October 21, 2004, FQHC services furnished to dual eligibles will be reimbursed reasonable cost which is equivalent to the provider specific prospective payment rate.

Effective for dates of service 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 FQHC encounter rate.

Separate encounters for DSMT services are not permitted and the delivery of DSMT services alone does not constitute an encounter visit.

Effective for dates of service on or after December 1, 2011, the Medicaid Program shall provide reimbursement for fluoride varnish applications rendered by qualified health care professionals to recipients under the age of 6 years in the FQHC encounter rate when performed on the same date of service as an office visit or preventative screening.

Separate encounters for fluoride varnish services are not permitted and the application of fluoride varnish does not constitute an encounter visit.

Alternate Payment Methodology

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 federally qualified health centers (FQHCs) 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.)

The reimbursement for adjunct services is a flat fee, based on the adjunct CPT code(s) regardless of practitioner (except dental), in addition to the reimbursement for the associated office encounter (PPS methodology). The agency's rates were set as of October 21, 2007 and are effective for services on or after that date. All rates are published on the agency's website (www.lamedicaid.com). 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.

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III. Standards for Payment

1. The FQHC must meet the Standards for Participation outlined in Attachment 3.1-A, Item 2.c.
2. The FQHC provider shall maintain an acceptable fiscal record keeping system that will enable the services provided by a FQHC to be readily distinguished from each other type of service which that facility may provide.
3. The FQHC provider shall retain all records as are necessary to disclose fully the extent of services provided to recipients; to furnish information regarding such records and regarding any payments claimed for providing such services as Medicaid of Louisiana, the Secretary, or the Medicaid Fraud Control Unit may request, for five years from date of service.
4. The FQHC provider shall abide by and adhere to all federal and state regulations, guidelines, policies, manuals, etc.

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