Billing Advice for FQHC-Run School-Based Health Centers

California Primary Care Association

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Agenda

1. Establishing FQHC Sites
2. Billing Nuances
3. Future of Medi-Cal Reimbursement for FQHCs

Establishing FQHC Sites

Focus Areas

How you establish your sites impacts how you get paid.

- HRSA Scope
- Site Licensure & Medi-Cal Enrollment
- PPS Rate Establishment
- Adjustment of a PPS Rate

HRSA Scope

Why It's Important:

- HRSA scope defines what FQHC sites and services are covered under the FQHC umbrella (scope exists at the organization-level – not by site). Some health center organizations operate services lines that are carved out of their HRSA scope, such as pharmacies. However, **nothing outside of the HRSA scope is eligible for PPS reimbursement.**
- Sites must be added to the HRSA scope before Medi-Cal will enroll the site as an FQHC (i.e. no PPS eligibility until the site is in HRSA scope).
- ***Note:** HRSA's definition of an intermittent site is not the same as the California licensure definition.

Site Licensure & Medi-Cal Enrollment

- CA Health and Safety Code Section 1204(a)
- Each site (or mobile unit) is either fully licensed or operates as an intermittent location
- Licensure process can range from ~2 months (fastest) to over 1 year

Licensed

- ✓ Must be in HRSA scope of project
- ✓ Application and approval by CDPH as a community clinic
- ✓ Subject to OSHPD 3 building standards
- ✓ Enrolled into the Medi-Cal program through application as community clinic
- ✓ Submit initial rate setting application to DHCS
- ✓ Interim PPS rate and Medi-Cal changes community clinic status to FQHC/RHC

Intermittent (40 hours or less per week)

- ✓ Must be in HRSA scope of project
- ✓ Must notify DHCS and CDPH
- ✓ Not subject to OSHPD 3 building standards
- ✓ Uses a parent location for Medi-Cal PPS billing
- ✓ Must separately enroll into FPACT, other state-based reimbursement programs

PPS Rate Establishment

Before submitting a PPS application for a new site:

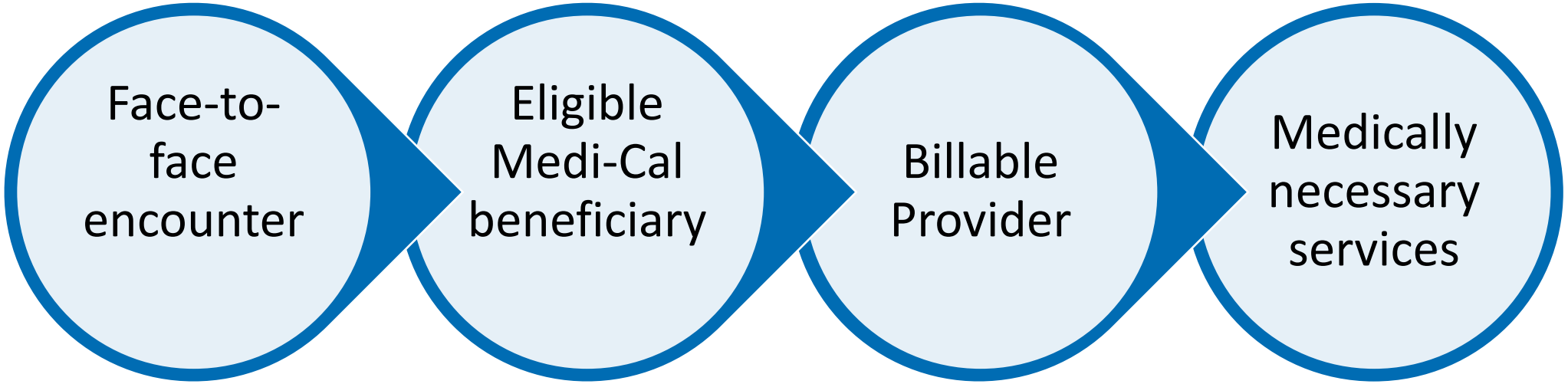
- Once the site is licensed, the organization can move forward with rate-setting by applying to do cost-based reimbursement or using the 3 comparable clinics method.
- FQHC must have HRSA documentation showing the date the site was approved in the HRSA's scope of project
- PPS application package must be submitted within 90 days of HRSA approval if FQHC wants the PPS effective date to be the same as federal effective date

Adjustment of a PPS Rate

- PPS rates receive an annual Medicare Economic Index (MEI) increase (~1.5%)
- FQHCs can choose to adjust their PPS rate by filing a change in scope of services request. There must be a triggering event (defined in Section K of the State Plan Amendment).
- Some service additions require a change in scope, such as adding dental hygienists or marriage and family therapists.
  - Example: school-based intermittent site adding a dental hygienist for the first time would be required to go through a CSOSR at the parent site unless dental hygienists had already been added to the parent site's PPS rate.

Billing Nuances

Billable Visits



Billable Providers:

- Physician
- Physician assistant
- Nurse practitioner
- Certified nurse midwife
- Psychologist
- Licensed clinical social worker
- Marriage & family therapist
- Dental hygienist
- Licensed acupuncturist
- Comprehensive Perinatal Services Program (CPSP) Practitioner

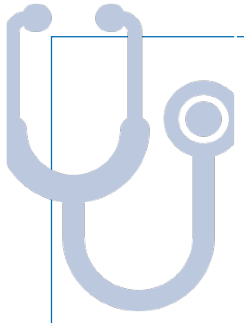
Medi-Cal Provider Manual: FQHC/RHC Section: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/rural.pdf

Same Day Limitations

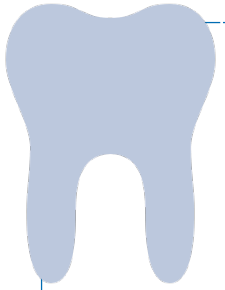
Encounters with more than one healthcare professional and multiple encounters with the same healthcare professional that take place on the same day and at a single location (same FQHC or RHC organization) constitute a single visit.

Senate Bill 316: allow FQHC or RHC to be reimbursed by Medi-Cal for a mental health that occurs on the same day as a medical or dental visit. The bill was held on the Assembly Floor to continue engagement with the administration.

Exceptions to the same day limitation:



1.When a patient, after the first visit, suffers illness or injury that requires another health diagnosis or treatment



When the patient has a medical and dental visit on the same day

Medi-Cal Provider Manual: FQHC/RHC Section: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/rural.pdf

Group Visits

- FQHCs can only bill one visit for the group visit
- If a managed care plan allows the billing for each individual person at the group visit, the FQHC can only submit one wrap around claim
- If each patient, who is participating in the group visit, has a face-to-face encounter with a billable provider who is rendering medically necessary services, the FQHC can bill for each qualifying visit.
- FQHCs are required to follow the Medi-Cal guidelines at all times when billing Medi-Cal claims (billable visit, same day limitation, incidental services, etc.)

Medi-Cal Managed Care Billing

Assigned Patient

- Bill Medi-Cal managed care plan according to the plan's billing requirements
- Bill the state for the wrap claim

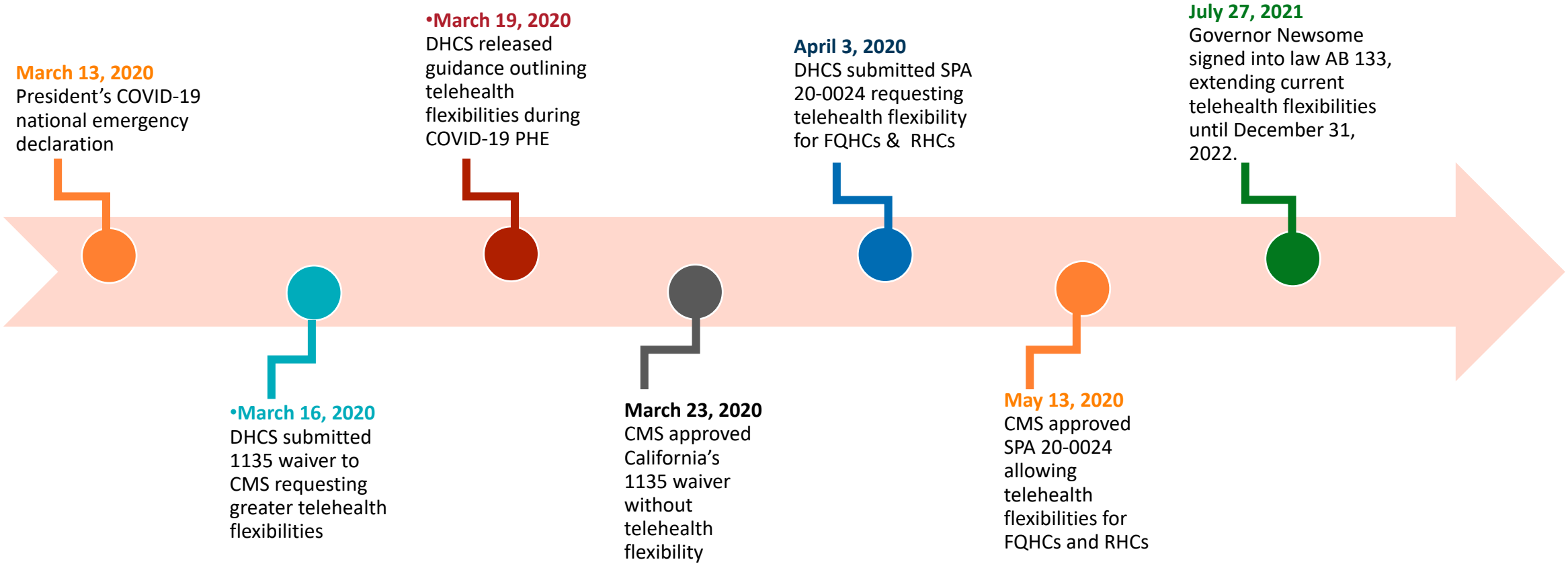
Out-of-Network Patient

Remind patient to see assigned provider in the future & document referral in patient's medical record

Bill Medi-Cal managed care plan then bill the state for the wrap claim (must attach proof of payment or denial from plan)

Medi-Cal Provider Manual: FQHC/RHC Section: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/rural.pdf

State Telehealth Flexibilities



SPA 20-0024: https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-20-0024-COVID-Approval.pdf
AB 133: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB133

Telehealth Flexibilities

	Before COVID-19	During COVID-19
Modality	-Synchronous telehealth -Asynchronous telehealth	-Synchronous telehealth -Asynchronous telehealth **-Telephone**
Eligible services	-All appropriate Medi-Cal services that are FQHC covered services	-No changes for the most part -AMFT and ACSW services are billable during COVID-19 PHE
Billable provider requirement	-A billing provider must be a billable provider	-No change
Established patient requirement	-Patients must be established -Asynchronous cannot be used to establish patient	-The established patient requirement is **waived**
Face-to-face requirement	-A visit must be a face-to-face encounter	-The face-to-face requirement is **waived**
Four-wall requirement	-Service must be rendered within the clinic's four walls	-The four-wall requirement is **waived**

Medi-Cal Telehealth Guidance: https://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_30339_02.aspx

Billing Medi-Cal for Telehealth Visits

Synchronous Telehealth

- Live video-conferencing between a patient and provider

PPS Reimbursement

- Bill Medi-Cal using the same process as other billable visits where the patient is in-person

Asynchronous Telehealth

- Transmission of medical data using store-and-forward technology

PPS Reimbursement

- Bill Medi-Cal using the same process as other billable visits where the patient is in-person

Telephonic Visit

- Telephonic visit that meets all DHCS documentation criteria

PPS Reimbursement

- Bill Medi-Cal using HIPPA-compliant billing code set
- Include appropriate corresponding CPT codes (i.e., 99201-99203 for "new" patients, and 99212-99214 for "established patients) on "informational" line

Telephonic Visit

- Telephonic visit that DOES NOT meet all DHCS documentation criteria

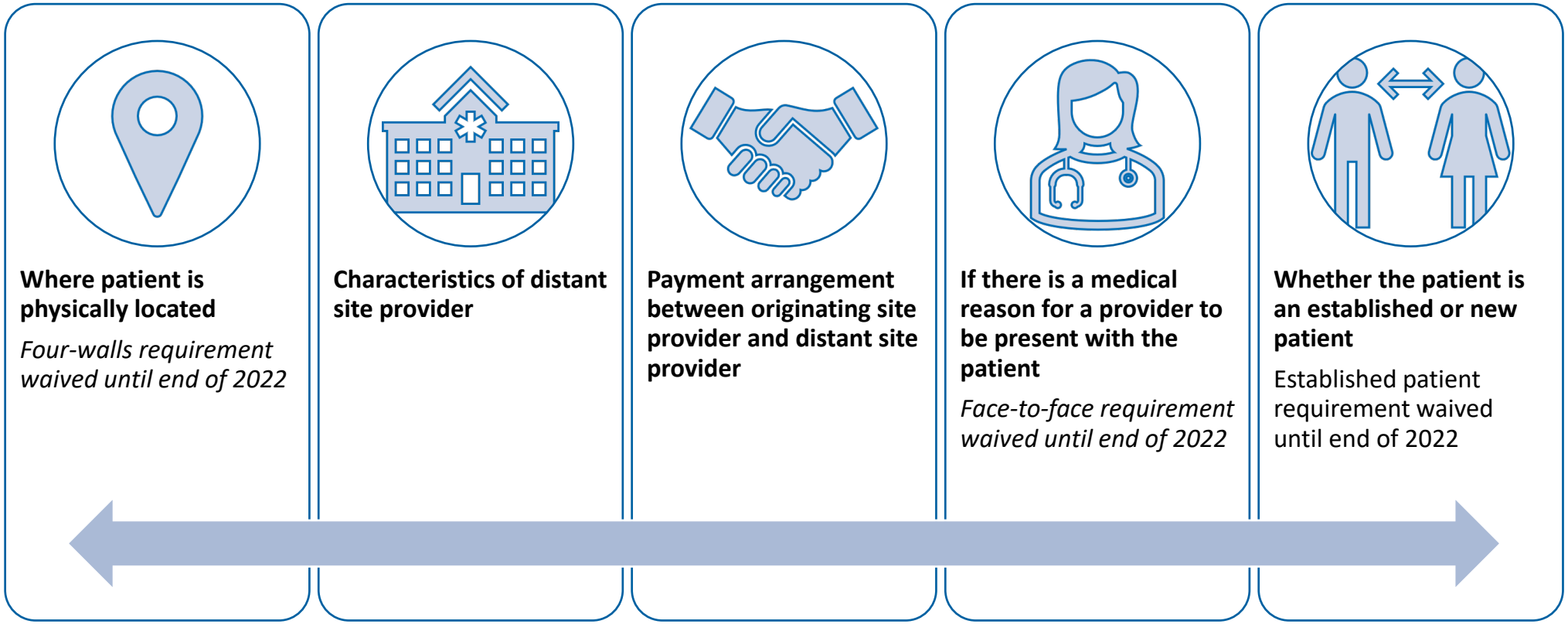
FFS Reimbursement

- Bill Medi-Cal with HCPCS code G0071 on the "payable" claim line
- Do not include a corresponding CPT code.

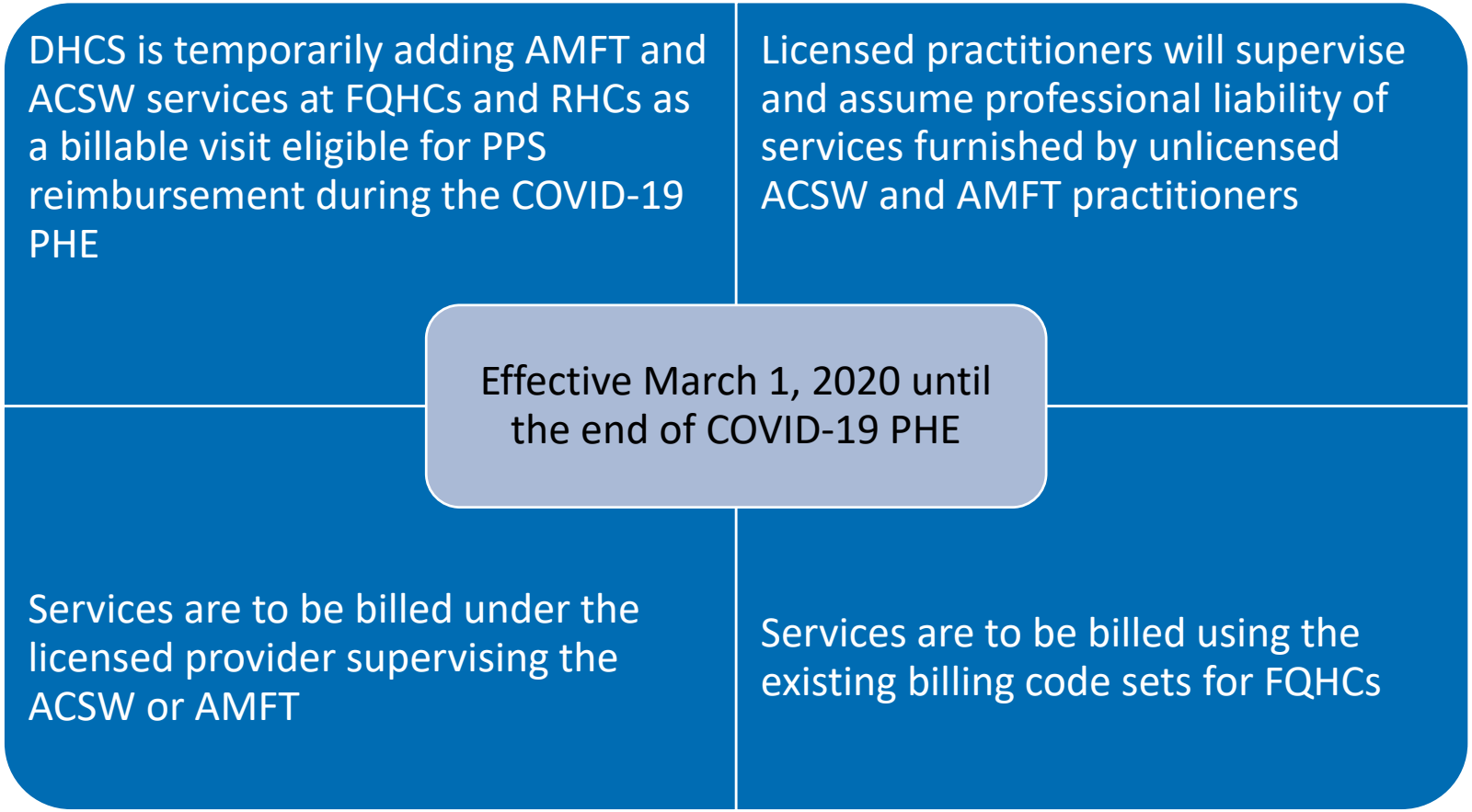
Medi-Cal Telehealth Guidance: https://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_30339_02.aspx

Billing Medi-Cal for Telehealth Visits Continued

Factors that determine how to bill for telehealth visits



Other Flexibilities: ACSWs & AMFTs



DHCS Guidance on ACSWs and AMFTs: https://www.dhcs.ca.gov/Documents/ACSWMFT-Covid19-NewsFlash-052020.pdf

Minor Consent Medi-Cal – Covered Benefits

- Family planning services
- Pregnancy and pregnancy-related services
- Outpatient mental health treatment and counseling (12+)
- Substance abuse counseling (12+)
- Sexually-transmitted disease treatment (12+)
- Sexual assault services

Aid Codes:

7M – STD, sexual assault, drug/alcohol abuse, family planning

7N – Pregnancy, family planning

7P - STD, sexual assault, drug and alcohol abuse, family planning, *outpatient mental health*

7R – Family planning, sexual assault

Minor Consent Medi-Cal - Eligibility

- < 21 years old
- Unmarried
- Living with a parent or guardian
- Based on OWN income and property only
- No residency/citizenship requirement

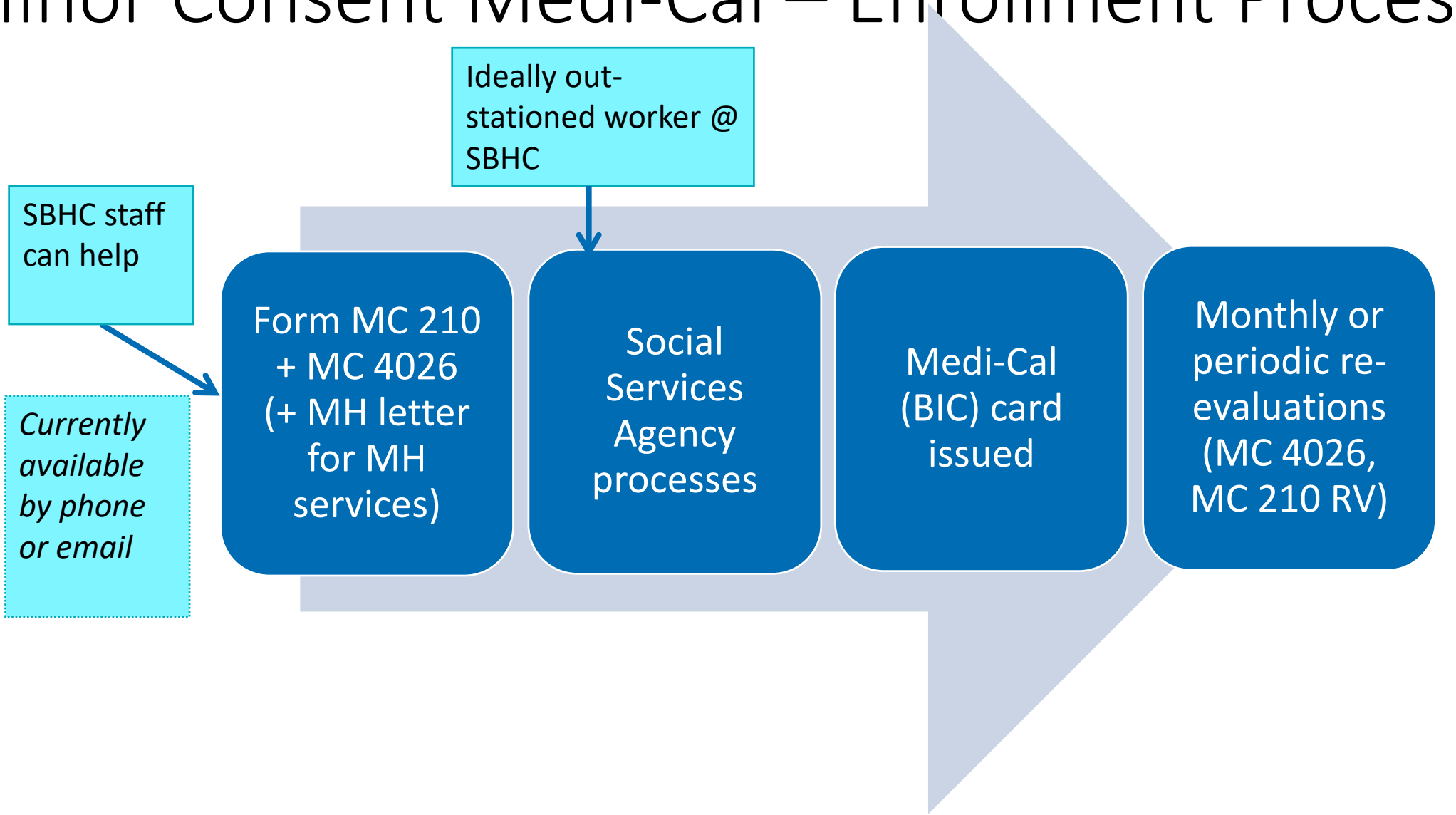
MH Severity Criteria

Mental health professional must attest that:

- The minor is mature enough to participate intelligently in the MH counseling AND:
  - Minor is in danger of causing serious physical or mental harm to themselves or others without MH treatment or counseling; OR
  - Minor is alleged victim of incest or child abuse

THIS REQUIRES A WRITTEN STATEMENT FROM THE MENTAL HEALTH PROFESSIONAL WHICH SPECIFIES ESTIMATED LENGTH OF TREATMENT NEEDED

Minor Consent Medi-Cal – Enrollment Process



Why This Matters: Implications for SBHCs

- Higher reimbursement rate for family planning services than FPACT
  - Caveats for LARCs and health education
- MH coverage for privately insured students that meet criteria
- More effort, more payoff
- Program ensures appropriate levels of confidentiality

Recommendations for SBHCs

- Talk to your County Social Services Agency
- Engage local Clinic Consortium
- Download our BH Billing Guide:
  - https://www.schoolhealthcenters.org/funding/mental-health/
- Maintain internal expertise and tracking mechanisms
- More info at:
  - https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/minor.pdf

Future of Medi-Cal Reimbursement for FQHCs

Future of Medi-Cal Reimbursement for FQHCs

- Future of Medi-Cal
- Managed Care Plan Procurement
- CalAIM
- APM
- What does any of it mean for school health clinics?

A New Direction in Medi-Cal

Principles

- **Data-driven improvements** that address the whole person
- **Transparency, accountability** and member involvement
- **Eliminating health disparities** through anti-racism and community-based partnerships

Goals

- **Engage members** as owners of their own care
- **Keep families and communities healthy** via prevention
- **Provide early interventions** for rising risk and patient-centered chronic disease management
- **Provide whole person care** for high risk populations, addressing drivers of health

Why it matters

When Denise Williams' baby boy was 2 months old, she became alarmed by a rattling sound in his lungs and took him to the emergency room. While undergoing treatment, he spiraled into a disabling neurological disorder.

Now 2 years old, Markeano is attached to breathing and feeding tubes. He can't walk or move his arms.

"Advocates, patients and even the state auditor say Medi-Cal has failed to hold accountable the managed-care health plans that cover almost 12 million of its nearly 14 million enrollees."

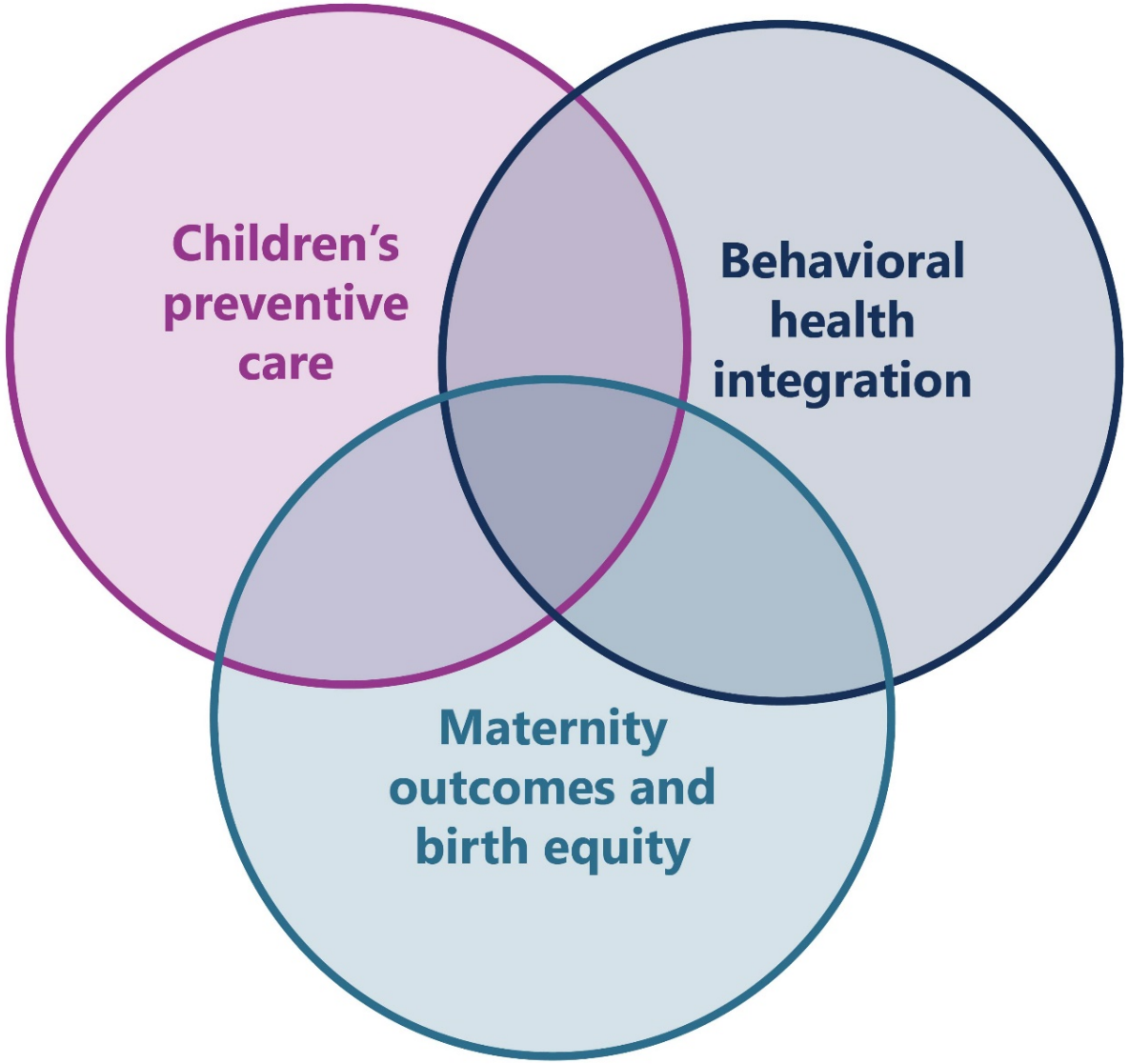
"Poor care coordination is one of the many shortcomings of Medi-Cal, which covers over a third of the state's population and nearly 40% of children under 18."

"Jacey Cooper, California's Medicaid director, said the state's focus will be assuring that plans provide access to care and are committed to improving the outcomes of Medi-Cal beneficiaries.

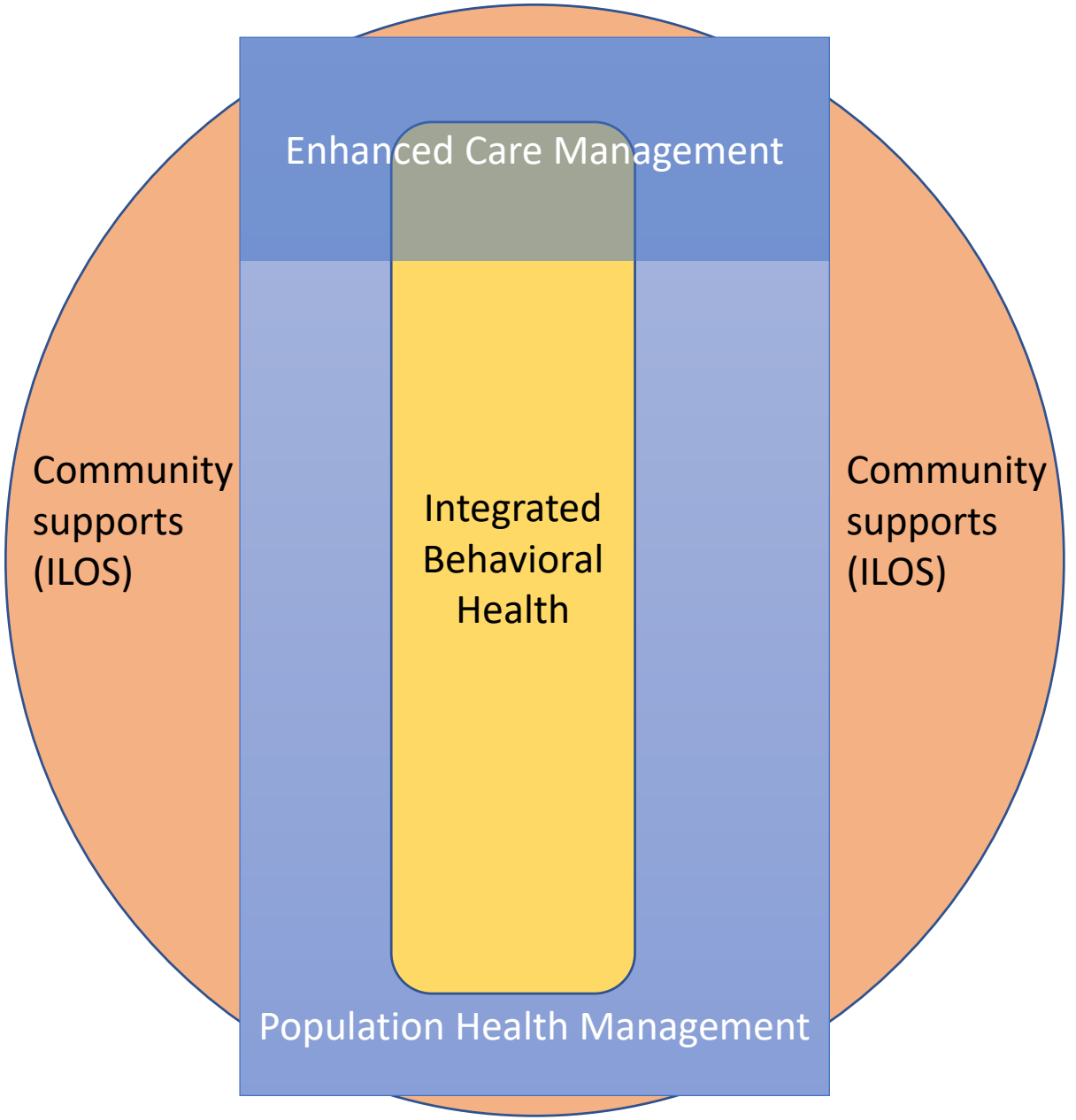
The recontracting process is intertwined with an ambitious $6 billion experiment to move Medi-Cal beyond medicine into the realm of social services."

https://www.willitsnews.com/2021/09/22/californias-reboot-of-troubled-medi-cal-puts-pressure-on-health-plans-2/

Medi-Cal Clinical Focus Areas



How CalAIM reshapes Medi-Cal



** Andie's visual depiction*

ECM and Community Supports

* ECM and ILOS will build on the design and learnings from California's Whole Person Care Pilots (WPC) and Health Homes Program (HHP) and will replace both models to scale interventions to a statewide care management approach.

Enhanced Care Management (ECM)

A Medi-Cal managed care benefit that will address clinical and non-clinical needs of high-need, high-cost individuals through the coordination of services and comprehensive care management.

Community Supports (formerly in lieu of services "ILOS")

Services that Medi-Cal managed care plans are strongly encouraged but not required to provide "in lieu of"/ as substitute for utilization of other services or settings such as hospital or skilled nursing facilitating admissions, discharge delays, or emergency department use.

Community health centers are foundational to Medi-Cal and CalAIM's success

Alignment in Medi-Cal Delivery System

CalAIM (DHCS)	Payment Modernization/ APM (FQHC)	Medi-Cal Procurement (Health Plans)
• Deliver **person-centered care** that meets the behavioral, developmental, physical, oral health and LTSS needs of all members. • Improve the **member experience**. • Identify and mitigate **social determinants of health and reduce disparities or inequities**. • Support **community activation and engagement**. • Work to **align funding, data reporting, quality and infrastructure** to mobilize and incentivize towards common goals. • Build a **data-driven population health management** strategy to achieve full system alignment. • Drive **system transformation** that focuses on **value and outcomes**. • Reduce the **per-capita cost** over time through iterative system transformation. • Eliminate or **reduce variation** across counties and plans, while recognizing the importance of local innovation. • Improve plan and provider experience by **reducing administrative burden** when possible.	• Care that is **patient-centered**, allowing members to receive needed services conveniently (e.g. via telehealth rather than in-person visits or via a broader range of care team providers). • Care of the **whole person**, including the integration of physical, behavioral and oral health services. • **Reduction in disparities** by allowing health centers more flexibility to address member needs, including social determinants of health. • **Alignment of measures** in CalAIM, Medi-Cal Managed Care, and Pay for Performance programs to ensure greatest impact in quality targets. • **Data informed innovation** that encourages deeper health information exchange between managed care plans and health centers. • Delivery reform that focuses on **value and outcomes**, and acknowledgement that investment in early intervention and primary care can result in per-capita cost decreases to the larger Medi-Cal program. • Health center experience as providers in Medi-Cal by reducing **administrative burden** and providing consistent and timely payment that helps to ensure a strong and resilient safety net in California.	• Manage members over time through a comprehensive array of **person-centered health and social services** spanning all levels of intensity of care, from birth to end of life. • Provide **coordinated, integrated care for all members**, particularly vulnerable populations with complex health care needs. • Identify **health disparities and inequities in access, utilization, and outcomes** and have focused efforts to improve health outcomes within the groups and communities most impacted by health disparities and inequities. • **Meet or exceed Minimum Performance Levels for quality**, on the measures included in the Managed Care Accountability Set. • Expand **access to evidence-based behavioral health services**, focused on earlier identification and engagement in treatment for children, youth, and adults. • Meet the **health needs of a members** through methods designed to capture SDOH through coding and articulating a care coordination strategy inclusive of SDOH. • Implement financial arrangements with health care providers that link **payments to value** in the form of higher quality of care, better health care outcomes, and lower cost of care. • **Reduce administrative waste and enhance efficiency**.

What CPCA has been working towards for over a decade

** Dozens of strategies to address all of the goals are also underway*

Overarching Framework for APM

- **Payment: Rate Conversion**
  - FQHCs in APM are guaranteed an APM based on historic PPS utilization at their current PPS rate / divided by assigned Medi-Cal beneficiary member months
  - This rate will be paid as a per member per month rate by FQHC site enrolled in the APM
- **Reporting: Quality and Alternative Care**
  - FQHCs are expected to engage in the quality and access reporting
    - encounter data to plans
    - alternative care/ non-traditional services CPT codes
    - 10-15 quality measures

Working Set of Quality Measures

APM Quality Category	Measure Name	Measure Abbreviation	Measure Steward
Prevention - Adult	Cervical Cancer Screening	CCS	NCQA
Prevention - Adult	Colorectal Cancer Screening	CMS130v9	NCQA
Prevention- Adult	*Breast Cancer Screening*	*BCS*	*NCQA*
Prevention - Peds	Child and Adolescent Well-Care Visits	WCV	NCQA
Prevention - Peds	Childhood Immunization Status (CIS 10)	CIS	NCQA
Prevention- Peds	*Fluoride Varnish*		*DQA*
BH Integration	*Use of opioids at high dosage*		
BH Integration	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	CDF	CMS
BH Integration	*Depression Remission or Response for Adolescents and Adults*	*DRR-E*	*NCQA*
Chronic Care	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	CDC-H9	NCQA
Chronic Care	Controlling High Blood Pressure	CBP	NCQA
Chronic Care	*Comprehensive Diabetes Care: Eye Exam*	*CDC-E*	*NCQA*
Patient Experience of Access and Care	CG-CAHPS: Provider Rating	CG-CAHPS	NCQA
Patient Experience of Access and Care	CG-CAHPS: Timeliness of receipt of requested appointment	CG-CAHPS	NCQA
Patient Experience of Access and Care	*CG-CAHPS: Would you recommend this provider….*		
Maternity Care	Prenatal and Postpartum Care (Postpartum Care)	PPC-Pst	NCQA
Maternity Care	Prenatal and Postpartum Care (Timeliness of Prenatal Care)	PPC-Pre	NCQA
Maternity Care	*Postpartum depression*		

Working list of Alternative Care Services

Domain	Alternative Touch
Communication	Email consultation with PCP
	Panel management
	Non-provider care team telehealth (e.g., texting; video-observed therapy; RN e-visit ; nurse advice line
Education	Wellness
	Health coach
	Patient support group
	CHW
	Health education
	Nutrition education
	Group medical visits
Case management	Complex care manager for non ecm patient
	Enhanced care management services by non-billable providers
	Case management for non ecm patient
Care Team Support	RN/LVN (nurse) only visit
	PharmD
	Home nursing visit (+ pre/postnatal home services)
	Mobile/street medicine with nonbillable (+ paramedic treat and release)
	eConsult (provider-provider)
	Remote patient monitoring
	Integrative medical therapy (e.g., acupuncture)
	Osteo/chiro
	Palliative care w/non billable provider care team members
	Pain management w/non billable provider
	Transportation (non-emergency medical and non-medical transportation)
	Physical/occupational therapy

Timeline to build and launch the APM

State/FQHCs/Plan formal meetings

- Started in April 2021
- Meet approximately 5-6 times in 2 hour meetings to discuss and come to general agreement on central elements of the methodology

State and CMS

- Final decisions of stakeholder group in December
- SPA concept crafted by Fall 2021
- Concept submitted to CMS in Dec/Jan 2021/22

State launch and FQHC Participation

- Application for APM released in Jan/Feb ‘22
- State selects FQHCs in in Spring ‘22
- Logistics/ rate setting middle part of ‘22
- Launch APM in 2023
- Then year over year FQHCs can apply at their discretion

FQHCs Highly Interested in APM 2.0

CHCs that were engaged in APM 1.0

1. Alexander Valley healthcare
2. Alliance Medical Center
3. Altura Centers for Health
4. APLA Health & Wellness
5. Asian Health Services
6. Bartz-Altdonna Community Health Center
7. Centro de Salud de la Comunidad de San Ysidro
8. Communicare Health Centers
9. Community Health Alliance of Pasadena
10. Community Health Systems, Inc.
11. Community Medical Centers, Inc.
12. Comprehensive Community Health Centers
13. East Valley Community Health Center
14. Eisner Health
15. El Proyecto del Barrio, Inc.
16. Family HealthCare Network
17. Golden Valley Health Centers
18. Health and Life Organization, Inc. (HALO)
19. HealthRIGHT 360
20. Hill Country
21. Imperial Beach Community Health Clinic
22. Inland Behavioral Health Services
23. La Clinica de La Raza, Inc
24. LifeLong Medical
25. Long Valley Health CEnter
26. Los Angeles LGBT Center
27. Marin Community Clinic
28. Mendocino Coast
29. Mendocino Community Health Clinic Inc.
30. Mountain Valleys Health Centers
31. Native American Health Center
32. Neighborhood Healthcare
33. North Eastern Rural Health Clinic
34. Northeast Valley Health Corporation
35. OLE Health
36. One Community Health
37. Open Door Community Health Centers
38. Peach Tree Healthcare
39. Redwoods Rural Health Center
40. Saban Community clinic
41. SAC Health
42. Sacramento Native American Health Center, Inc
43. Salud Para la Gente
44. San Mateo Medical Center
45. Santa Barbara Neighborhood Clinics
46. Share Our Selves
47. Shasta Community Health Center
48. Sonoma Valley Community Health Center
49. South Bay Family Health Care
50. South Central Family Health Center
51. South of Market Health Center
52. St.John's Well Child and Family Center
53. St. Jude Neighborhood Health Centers
54. St. Vincent de Paul Village Family Health Center
55. Tarzana Treatment Center
56. Tiburcio Vasquez Health Center
57. TrueCare formerly North County Health Services
58. UMMA
59. Valley Community Healthcare
60. Venice Family Clinic
61. Vista Community Clinic
62. West County Health Centers
63. White Memorial Community Health Center
64. Winters Healthcare

What does it mean for School Health Clinics?

Kids are VERY important to Medi-Cal

It is a PRIME moment for school health clinics

= OPPORTUNITY ☺

How does the APM impact School Health Clinics?

- School Clinic Sites that are part of FQHCs that apply for APM are included
  - If the school clinic is an individually licensed site receiving a PPS rate and has assigned lives it can apply for the APM and receive a direct PMPM
  - If the school clinic is an intermittent site and the parent site is part of the APM then the school clinic is automatically included in the APM

What does it mean for School Health Clinics?

- Opportunity for using non-billable providers
- Opportunity for delivering care in more creative ways
- Opportunity to keep getting paid even if billable visits not being done

What can you be doing?

- Make sure you know what's going on in your organization.
- Do you know if your school clinic is an intermittent site or has assigned lives?
- Pull the data on the children quality measures and see how you are doing? Would the APM help improve the scores?
- What other programs that touch kids impact your clinic?

Questions?

Resources

HRSA

- Health Center Program - https://bphc.hrsa.gov/programrequirements

Federal

- Social Security Act (SSA §§ 1861(aa), 1902, and 1905)
- Federal regulations (42 C.F.R. Parts 440 and 447 Medicaid services and provider payment)
  - No federal regulations implementing FQHC PPS → States

Federal & State Relationship

- Medicaid State Plan Agreement between a state and federal government describing how the state administers it's Medicaid programs
- Assures state will abide by federal rules for claiming federal matching funds
- If a state wants to make program changes, corrections, or updates, they send state plan amendments (SPA) to CMS for review and approval

State

- Welfare and Institutions Codes (WIC § 14132.100 – 14132.108 and 14087.325)
- Current State Plan - https://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx
  - Attachment 4.19-B (pg. 6-11) FQHCs/RHCs - https://www.dhcs.ca.gov/formsandpubs/laws/Pages/Attachment419-B.aspx
  - Limitations on Attachment 3.1-A - https://www.dhcs.ca.gov/formsandpubs/laws/Pages/Section3.aspx
- Medi-Cal Provider Manual (RHCs and FQHCs) - https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/rural.pdf
- Medi-Cal Waivers - https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx

Thank You.