Federally Qualified Health Center
WRAP Supplemental Payment
Reference Guide
(July 2019)

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WRAP Supplemental Payment Process Overview

A Medicaid Eligible patient who is assigned to a Managed Care Organization (MCO) is provided services by an FQHC.

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The FQHC bills the MCO for the services provided to the patient and is reimbursed the contracted amount from the MCO.

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The FQHC gathers all such claims for the time period being submitted (quarterly, monthly) and submits the data to DHCFP.

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DHCFP calculates how many encounters the FQHC provided to eligible members in the time period. This number is used to calculate the Total Core PPS rate due to the FQHC. DHCFP then deducts the amounts already paid by the MCO from the Total Core PPS rate.

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The balance is the WRAP Supplemental Payment.

Example:

1. FQHC submits a file containing 1,000 encounters.
   (*In this example, The FQHC's PPS rate is $138.50 per encounter.)*

2. The Total Core PPS rate due is $138,500.00 (1,000 x $138.50 each)

3. The MCO amount already paid on those encounters is $65,000.00.

The WRAP payment is calculated:

PPS Rate:	$138,500.00	(1,000 encounters x $138.50 each)
Less		
MCO Paid:	$65,000.00	(Total already paid on the encounters)
WRAP:	**$73,500.00**	**(WRAP Supplemental Payment)**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Nevada

Attachment 4.19-B
Page 1 (Continued)

c. **Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)**

Nevada Medicaid uses a Prospective Payment System (PPS) for FQHCs/RHCs as required by S.S.A. §1902 (a) (15) [42 U.S.C. § 1396a (a) (15)] and S.S.A. §1902 (bb) [42 U.S.C. §1396a (bb)]. The PPS for FQHCs/RHCs was implemented and took effect on January 1, 2001.

Prospective Payment System (PPS) Reimbursement for Existing Facilities

On January 1, 2001 the State began paying FQHCs/RHCs (including "FQHC look alike clinics") based on a PPS rate methodology, per CMS requirements. The baseline for a PPS was set at 100 percent of the average of an FQHC/RHC per visit rate based on the reported reasonable and allowable costs of providing Medicaid-covered services during the FQHC/RHC fiscal years 1999 and 2000, adjusted to take into account any reported increase (or decrease) in the scope of services furnished during FY 2001 by the FQHC/RHC (calculating the payment amount on a per visit basis). Medicaid-covered services that are considered to be FQHC/RHC services are those services that were identified and approved to be provided by the facility as it applies to HRSA in order to be deemed as an FQHC/RHC facility.

Beginning in Federal fiscal year 2002, and for each fiscal year thereafter, each FQHC/RHC is entitled to the payment amount (on a per visit basis) to which the center or clinic was entitled under the Act in the previous year, increased each October 1st (FFY) by the percentage increase (or decrease) in the Medicare Economic Index (MEI) for primary care services as defined in Section 1842 (i) (3) of the Social Security Act, which is intended to account for the basic cost increases associated with providing such services.

After February 6, 2016, the DHCFP will allow reimbursement for up to three encounters/visits per person per day provided that the FQHC has separate PPS rates for each reimbursable service type; medical, behavioral health and dental. FQHCs that only provide two of the specified service types will be allowed reimbursement for up to two encounters/visits per patient per day. For FQHCs that only have one PPS rate will be allowed reimbursement for only one encounter/visit per patient per day. For FQHCs that do not have separate Service Specific Prospective Payment Systems (SSPPS) rates already established, they may opt to change to an Alternative Payment Methodology (APM) wherein their costs/visits will be reviewed after a full year of providing and receiving reimbursement for up to three (or two) visits/encounters per patient per day, resulting in separate Service Specific Alternative Payment Methodology (SSAPM) rates being established.

FQHCs may choose to retain their current SSPPS rates and not bill up to three encounters/visits per patient per day, which will not result in a change to an SSAPM and a current review of their costs and visits.

PPS rates will not be subject to rebasing after their initial computation unless authorized by Congress. Only the actual costs related to any reported change in scope of services will be calculated (based on a full year of providing those services) and an adjustment or add-on to the baseline PPS rate will be made. Any other changes to the PPS rate(s) will be considered an APM and will be outlined below in this State plan.

Prospective Payment System (PPS)-Service Specific Reimbursement for New Facilities

Newly qualified FQHCs/RHCs after Federal fiscal year 2012 will have initial payments (interim Service Specific PPS (SSPPS) rates) established either by reference to payments to one or more other clinics in the same or adjacent areas with similar caseloads and/or similar scope of services or based on an average of rates for other FQHC/RHC clinics throughout the State.

Once their average per visit reasonable costs of providing Medicaid-covered services based on their first full year of operation can be determined, the initial interim SSPPS payments of the FQHC/RHC will be cost settled and any over or under payments will be reconciled and the SSPPS rate will then be established based on the actual cost to provide those services for their first full year. The per visit SSPPS rate(s) will then be adjusted annually every October 1st beginning at the next federal fiscal year by the percentage change in the Medicare Economic Index (MEI) for primary care services as defined in Section 1842 (i) (3) of the Social Security Act, for that calendar year as published in the Federal Register. The MEI adjustment is the mechanism used to account for the basic cost increases associated with providing such services. All required documentation of actual costs for the first full year of providing services must be furnished to the DHCFP no later than six (6) months after completion of the first full year of services. If the required documentation is not received within six (6) months after the completion of a full year of services, the annual MEI adjustments will be suspended until such time as the documentation is received and an actual SSPPS rate is determined.

PPS/SSPPS rates will not be subject to rebasing after their initial computation unless authorized by Congress. Only the actual costs related to any reported change in scope of services will be calculated (based on a full year of providing those services) and an adjustment or add-on to the baseline PPS/SSPPS rate will be made. Any other changes to the PPS/SSPPS rate(s) will be considered an Alternative Payment Methodology (APM) and will be outlined below in this State Plan.

Alternative Payment Methodology (APM) Reimbursement

For any fiscal year after FY 2002, a State may use an APM methodology other than the Medicaid PPS, but only if the following statutory requirements are met. First, the APM must be agreed to by the State and by each individual FQHC/RHC to which the State wishes to apply the methodology. Second, the methodology must result in a payment to the center or clinic that is a least equal to the amount to which the center or clinic is entitled under the Medicaid PPS. Third, the methodology must be described in the approved State plan.

Service Specific APM (SSAPM) rates are based on the specific service type being provided. SSAPM rates are set at 100 percent of the average of an FQHC/RHC per visit rate based on the reported reasonable and allowable costs of providing Medicaid-covered services during the time period under review (calculating the payment amount on a per visit basis per service type). For FQHCs that have separate service specific APM rates established, the DHCFP will allow reimbursement for up to three (or two) SSAPM encounters/visits per patient per day for the different service types: one medical, one behavioral health and one dental.

Effective October 1st (FFY) of each year after an SSAPM rate has been established, for services

furnished on or after that date, the DHCFP will adjust the SSAPM rate by the percentage increase in the MEI applicable to primary care services as published in the Federal Register for that calendar year, which will account for basic cost increases associated with providing such services.

APM to Reflect Other Payment Adjustments

FQHC/RHC's may request an APM to reflect other payment adjustments in the event of extraordinary circumstances, not otherwise reimbursed by other sources, including but not limited to acts of God; acts of nature; acts of terrorism and acts of war. However, if an FQHC/RHC's existing PPS/SSPPS/SSAPM rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, other payment adjustment is not warranted. The FQHC/RHC must show that its PPS/SSPPS/SSAPM rate is not sufficient to cover the costs associated with the extraordinary circumstance. The adjusted rate will only apply to the extent, and only for the period of time, that the additional costs for the event are reimbursable under federal Medicaid law and regulations governing claims for federal financial participation (FMAP). The DHCFP will work with the provider to gather the appropriate data at the time the incident occurs and a written request for a rate adjustment is made by the Provider.

Change in Scope of Services

PPS/SSPPS/SSAPM rates may be adjusted to take into account any requested, documented and approved increase (or decrease) in the scope of services furnished by the FQHC/RHC in any given fiscal year. The FQHC/RHC must submit a written request detailing the change in scope of services to the Division within 60 days of the effective date of those changes in order for the rate adjustment to be retroactive to the date of the Change in Scope of Services. If a written request is not received within 60 days of those changes, the effective date for a rate adjustment will be the date the written request for a Change in Scope of Services was received by the DHCFP. Documentation and notification to support an increase or decrease in the scope of services is the responsibility of the provider and must specify all the changes up for review.

An FQHC/RHC requesting a rate adjustment for changes in scope of services must submit data/documentation/schedules that substantiate the changes in scope and the related adjustment of reasonable costs following Medicare principals of reimbursement.

An interim rate will be determined using the first three months of actual cost data available from the provider. After a full year of providing the services related to the change in scope, an analysis will be performed on the actual costs for a full year of service and an adjustment will be made to the PPS/SSPPS/SSAPM. Adjustments to the PPS/SSPPS/SSAPM rate for qualified/approved changes in scope will be based on Medicare Cost Reimbursement methodology, allocating costs related to patient care based upon a providers audited and approved costs for the change in scope services. The PPS/SSPPS/SSAPM rate adjustment will then be determined by dividing the approved allocated costs by the number of approved total visits for the given time period.

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A Change in Scope of Services has been defined as a change in the type, intensity, duration and/or amount of any service that meets the definition of FQHC/RHC services as defined in section 1905 (a) (2) (B) and (C) of the Social Security Act; and the service is included as a covered Medicaid service under the Medicaid state plan. General increases or decreases in costs associated with programs that were already a part of an established PPS/SSPPS/SSAPM rate do NOT constitute a Change in Scope. A Change in Scope must meet all of the following requirements:

- The change in the scope of services is a change in the type, intensity, duration, or amount of services, or any combination thereof as defined in section 1905 (a) (2) (B) and (C) of the Social Security Act.

- The cost is allowable under Medicare reasonable cost principals set forth in 45 CFR Part 75 Uniform Administrative Requirements, Cost Principles and Audit Requirements for HHS Awards and /or 42CFR Part 413 Principles of Reasonable Cost Reimbursement.

- The net change in the FQHC/RHC's per visit PPS/SSPPS/APM rate must equal or exceed 4% for the affected FQHC/RHC site(s). For FQHC/RHC's that filed consolidated cost reports for multiple sites to establish the initial Prospective Payment reimbursement rate (PPS), the 4% threshold will be applied to the average per visit rate (medical, dental and mental health) of all sites that provide the specific service for the purposes of calculating the cost associated with a scope of service change. "Net change" means the per visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year for the specific service type.

A Change in Scope of Services includes any of the following:

- A change in the types of services offered, i.e., the addition of dental services, may qualify as a Change in Scope which may warrant an adjustment to the PPS/SSPPS/SSAPM rate or the establishment of a new PPS/SSPPS/SSAPM rate.

- A change in intensity/duration or character of services offered by an FQHC/RHC attributable to changes in the types of patients served may qualify, such as services to patients with HIV/AIDS or other chronic diseases and other special populations requiring more intensive and frequent care.

- A change in the magnitude, intensity or character of currently offered services, demonstrated and documented by an increase or decrease in the patient volume of certain high risk populations that require more intensive and frequent care, which may reasonably be expected to span at least one year may qualify.

- A change in the type, intensity, duration or amount of service caused by changes in technology and medical practice used may qualify.

If a Change in Scope rate increase request is denied, the provider may request a formal rate appeal from the DHCFP. Rate appeal procedures are defined in the Medicaid Service Manual (MSM) Chapter 700.

Definition of a "Visit"/"Encounter"

A "visit" or an "encounter" for the purposes of reimbursing FQHC/RHC services is defined as face- to-face contact with one or more qualified health professionals and multiple contacts with the same health professional that take place on the same day with the same patient for the same service type.

Qualified Health Professional

To be eligible for PPS/SSPPS/SSAPM reimbursement, services must be delivered exclusively by one or more of the following licensed Qualified Health Professionals or a provider working under his or her direct supervision: Physician, Osteopath, Podiatrist, Physician's Assistant, Advanced Practice Registered Nurse, Certified Nurse Midwife, Clinical Psychologist, Clinical Social Worker, Dentist or Dental Hygienist and other Medicaid Qualified Providers.

Documentation Required to Support a Request for Change in Scope of Services

- Year End Payroll Reports for identified time periods
- Trial Balances for all Revenues and Expenses for identified time periods
- Grouping Schedule/Mapping of Trial Balance Accounts to the Cost Reports
- Detailed General Ledger with Vendor Information for identified time periods
- Claims reports showing Unique Patient Visits, DOS, Procedure Codes, Service Facility ID#, Amount Paid and Payer
- Other Items as Deemed Necessary

Record keeping and Audit

All participating FQHC/RHC's shall maintain an accounting system which identifies costs in a manner that conforms to generally accepted accounting principles and must maintain documentation sufficient to support all cost/visit data.

The DHCFP, its fiscal agent or a designated and contracted financial entity may conduct periodic on-site or desk audits of all cost data, including financial and statistical records of the FQHCs/RHCs.

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FQHCs/RHCs must submit information (statistics, costs and financial data or other data) as deemed necessary by the DHCFP or its fiscal agent. Failure to submit requested documentation may result in denial of a rate adjustment request.

The DHCFP will conduct one audit annually (at a minimum) to the claims submitted by the FQHC/RHC for supplemental payments.

Supplemental Payments for FQHCs/RHCs Enrolled with a Managed Care Entity (MCE)

FQHCs/RHCs that provide services under a contract with a Medicaid Managed Care Entity (MCE) will receive quarterly or monthly (as agreed upon between the provider and the state) supplemental payments for furnishing such services, that are a calculation of the difference between the payments the FQHC/RHC receives from the MCE(s) for all qualified Medicaid FQHC/RHC visits and the payments the FQHC/RHC would have received under the PPS/SSPPS or SSAPM methodology.

At the end of each payment period, the total amount of MCE payments received by the FQHC/RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's/RHC's contract with MCE(s) would have yielded under the PPS/SSPPS/SSAPM methodology. If the amount exceeds the total amount of MCE payments, the FQHC/RHC will be paid the difference, if the amount is less, the FQHC/RHC will refund the difference to the DHCFP. The FQHC/RHCs must provide sufficient documentation (as requested) to the DHCFP to facilitate supplemental payment calculations. If the required documentation is not provided to support the supplemental payment, future supplemental payments may be suspended.

Documentation Required to Calculate/Support Supplemental Payments

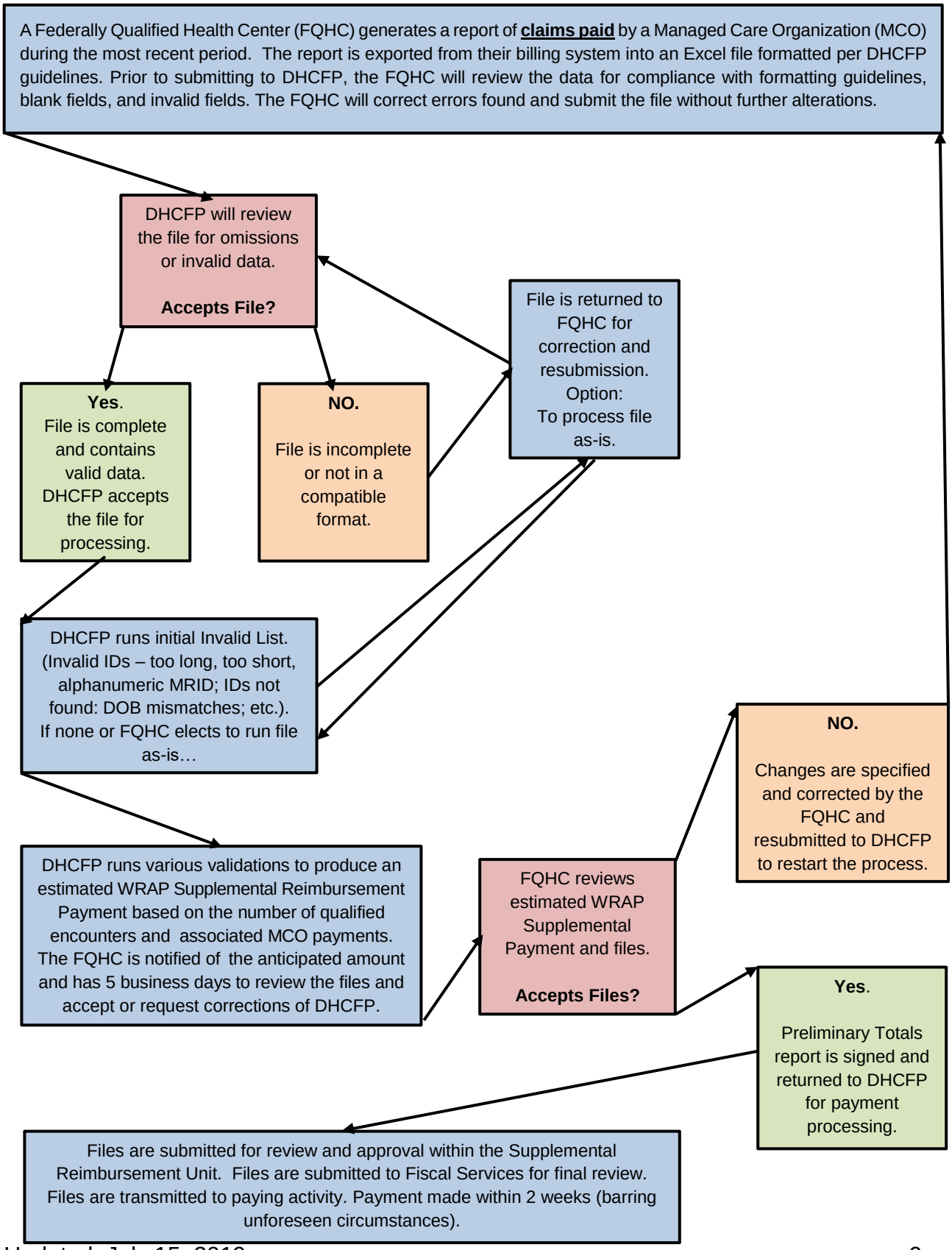
The FQHC/RHC will submit an electronic request for supplemental payment which will contain at least the following information for each line item of every qualified encounter during the reporting time period (Quarterly or Monthly): Medicaid Billing Provider ID#, Recipient MCE ID Number, Recipient Medicaid ID Number, Date of Service, Procedure Code(s), MCE Name, Total Billed Amount, MCE Paid Amount, Other Paid Amount, Total Amount Paid and Recipient Date of Birth.

The FQHC/RHC will submit claim data for supplemental payment no later than thirty days after the end of the reporting period agreed upon with the DHCFP (Quarterly or Monthly).

Any discrepancy found in the audits will be adjusted based on the audit findings.

DHCFP

WRAP Supplemental Payment Submission Process



WRAP Supplemental Payment Data Guidelines
(updated July 15, 2019)

In an effort to fully reflect the Medicaid policy related to the submission, processing and payment of supplemental WRAP claims, the following data guidelines will be effective July 15, 2019:

1. The data submitted for supplemental payment will contain only raw data, exported from the FQHC's billing system into an Excel file per the following the guidelines and formatting. The FQHC will not make any calculations to the data submitted:

(The corresponding Excel format required for each item is listed to the right)

ITEM	FORMAT
Provider Medicaid ID	Text (TX)
MCO Recipient ID	Text (TX)
Medicaid Recipient ID*	Text (TX)
Date of Service	Date (mm/dd/yyyy)
CPT code	Text (TX)
MCO Name	Text (TX)
Total Amount Billed	Currency ($)
MCE Paid Amount	Currency ($)
Other Paid Amount	Currency ($)
Total Paid Amount	Currency ($)
Date of Birth	Date (mm/dd/yyyy)

2. DHCFP will run the validation process over the raw data and calculate the expected reimbursement. The FQHC will be notified of the results and will have five (5) business days for acceptance or request correction. Signed Preliminary Totals report deadline is Wednesday by noon to ensure payment documents are routed that week.
3. After five (5) business days or upon notification from the FQHC, DHCFP will finish processing the WRAP data and authorize the appropriate supplemental payment be made.
4. Payment processing takes an additional five (5) to ten (10) business days. The Fiscal Services Unit (FSU) at DHCFP verifies the request and forwards it to Nevada Medicaid's fiscal agent, DXC. DXC processes payment requests on Saturdays for the following Friday's remittance.

Three Encounters per Day Guidelines

1. The data submitted to DHCFP staff for supplemental payment will be separated into, at most, three tabs in the Excel workbook corresponding to the type of claim: Medical, Dental, and Behavioral Health.
2. In order to receive the correct encounter rate for different types of encounters occurring on the same date for the same recipient, the claim lines for each type of visit must appear on separate tabs in the Excel workbook. Failure to differentiate between these claim types could result in an encounter not being identified correctly during processing, and therefore not being paid.

An FQHC enrolled as a Medicaid provider prior to 2012, may opt for an Alternative Payment Method per State Plan, Attachment 4.19-B. These providers will receive reimbursement for only one encounter per recipient per day and will use the combined Medical/Behavioral Health Submission and the Dental Tabs only. Dental and Medical/Behavioral data will be cross checked to ensure only one encounter receives the WRAP payment; the highest rate will be the one paid should both occur on the same date.

Division of Health Care Financing and Policy
Supplemental Reimbursement Unit
FQHC and RHC Medical Supplemental Payment Claim

Provider Name: **End of Billing Cycle Date (MMMYY):**

TX	*TX*	*TX*	*Date*	*TX*	*TX*	*$*	*$*	*$*	*$*	*Date*
Provider ID Number	MCO-Recipient ID Number	Medicaid Recipient ID # 11-Digits	Date of Service	CPT Code	Managed Care Organization (MCO) Name	Total Billed Amount ($)	MCO Paid Amount ($)	Other Paid Amount ($)	Total Paid Amount ($)	Recipient DOB

Division of Health Care Financing and Policy
Supplemental Reimbursement Unit
FQHC and RHC Dental Supplemental Payment Claim

Provider Name: **End of Billing Cycle Date (MMMYY):**

TX	*TX*	*TX*	*Date*	*TX*	*TX*	*$*	*$*	*$*	*$*	*Date*
Provider ID Number BILLING	MCO-Recipient ID Number	Medicaid Recipient ID # 11-Digits	Date of Service	CDT Code	Managed Care Organization (MCO) Name	Total Billed Amount ($)	MCO Paid Amount ($)	Other Paid Amount ($)	Total Paid Amount ($)	Recipient DOB

Division of Health Care Financing and Policy
Supplemental Reimbursement Unit
FQHC and RHC Behavioral Health Supplemental Payment Claim

Provider Name: **End of Billing Cycle Date (MMMYY):**

TX	*TX*	*TX*	*Date*	*TX*	*TX*	*$*	*$*	*$*	*$*	*Date*
Provider ID Number BILLING	MCO-Recipient ID Number	Medicaid Recipient ID # 11-Digits	Date of Service	CDT Code	Managed Care Organization (MCO) Name	Total Billed Amount ($)	MCO Paid Amount ($)	Other Paid Amount ($)	Total Paid Amount ($)	Recipient DOB

Division of Health Care Financing and Policy
Supplemental Reimbursement Unit
FQHC and RHC Medical/Behavioral Health Supplemental Payment Claim

Provider Name: **End of Billing Cycle Date (MMMYY):**

TX	*TX*	*TX*	*Date*	*TX*	*TX*	*$*	*$*	*$*	*$*	*Date*
Provider ID Number BILLING	MCO-Recipient ID Number	Medicaid Recipient ID # 11-Digits	Date of Service	CDT Code	Managed Care Organization (MCO) Name	Total Billed Amount ($)	MCO Paid Amount ($)	Other Paid Amount ($)	Total Paid Amount ($)	Recipient DOB