**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES**
**OTHER TYPES OF CARE**

Payment for Federally Qualified Health Center Services

Effective January 1, 2001 payments to Federally Qualified Health Centers for Medicaid covered services during State fiscal year 2001 will be paid on a per visit basis. The methodology described below is in accordance with the provisions of the Benefits Improvement and Protection Act (BIPA) of 2000.

A per visit rate for each facility will be determined based on 100 percent of the average facility's reasonable costs for providing all Medicaid covered services (including other ambulatory services) during State fiscal year 1999 and State fiscal year 2000. The averaging methodology is as follows: total costs for 1999 and 2000 will be added together and divided by the number of visits.

The per visit rate will be adjusted to account for any increase or decrease in the scope of services furnished during State fiscal year 2001. This adjustment will be calculated based on a review of available financial or statistical information, including data submitted on cost reports and special surveys to calculate any base rate adjustment. Each facility will be responsible for supplying the needed documentation to the OHCA.

Beginning with State fiscal year 2002 (July 1, 2001) and each State fiscal year thereafter, each facility's per visit rate will be inflated by the percentage increase in the Medicare Economic Index (MEI) for primary care services. Each facility's per visit rate will also be adjusted to account for any increase or decrease in the scope of services using the methodology described in paragraph 3 above.

Federally Qualified Health Centers that enroll in Medicaid after State fiscal year 2000 will have their initial per visit rate established either by reference to payments to other Federally Qualified Health Centers in the same or adjacent areas, or in the absence of such other clinics, through cost reporting methods. After the initial year, the per visit rate shall be established using the facility's reasonable costs inflated by the increase in the MEI.

FQHC Alternative Payment Methodology

Payments to FQHCs will be determined using an alternative payment methodology (APM) as authorized in Section 1902(bb) (6) of the SSA. The APM will be effective on or after the date the clinic has signed an agreement with Agency. Those FQHCs that do not choose the APM will continue to be paid under the current Prospective Payment System (PPS) method.

The APM will convert the clinic's current PPS rate into an equivalent Per Member Per Month (PMPM) rate using historical utilization and the PPS rate for the FQHCs. The base rate is determined as illustrated:

- FQHC PPS rate = $180 / encounter;
- FQHC served 1000 Medicaid patients at an average of 4.0 encounters / patient, for total Medicaid encounter revenue of $720,000;
- APM rate $720,000 / 1000 = $720 per patient, per year;
- FQHC PMPM is $720 / 12 = $60 PMPM.

The conversion of the clinic's PPS rate to a PMPM includes estimates of the number of members that will be served by the clinic as well as the average number of encounters.

After the initial year, the APM rate will be reviewed annually.

The PMPM is not actuarial certified and may not result in the final payment to the FQHC. On a quarterly basis, these estimates will be reconciled to actual utilization data in order to monitor whether the payments will be in accordance with 1902 (bb) of the SSA. To ensure that the appropriate amounts are being paid to each FQHC, the State will perform an annual reconciliation to verify the quarterly settlement payments were in compliance with Section 1902(bb) (6) (B).