

METHODS AND STANDARDS FOR ESTABLISHING PAYMENTS RATES-OTHER TYPES OF CARE

SERVICE	LIMITATIONS
3. Outpatient Clinic Services	State Agency Fee Schedule Based on Established Criteria.*
4. Dental Services	Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of dental services. The agency's fee schedule rate was set as of September 30, 2011, and is effective for services provided on or after that date. All rates are published on the agency's website at http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/p_002906.pdf
5. Home Health Services	Established fee per visit and mileage allowance.
6. Transportation for recipients is available in two modes: Ambulance (both emergency and non-emergency) and non-emergency non-ambulance	
I. Transportation – Emergency and Non-Emergency Ambulance	Payment is based on a flat fee per trip plus a fee for each mile over 20 miles per trip.
II. Transportation – Non-Emergency Medical Transportation	Transportation provided through section 1902(a)(70) non-emergency medical transportation brokerage program.
III. Brokerage Program	Payment is made based on a capitated Per member, Per Month Fee (PMPM).
7. Rural Health Clinic Services	Payment is made on the basis of an all-inclusive visit fee established by the Department. See below for descriptions of the prospective payment system (PPS) and supplemental payments under managed care.
8. Federally Qualified Health Center Services	For core services, payment is made on the basis of an all-inclusive visit fee established by the Department. See below for descriptions of the PPS and supplemental payments for managed care enrollees.
	Prospective Payment System
	a. For the period January 1, 2001, through September 30, 2001, the Department will pay FQHCs/RHCs, on a per visit basis, 100% of the average of their audited reasonable costs related to the provision of Medicaid covered services during Fiscal Years 1999 and 2000, adjusted to account for any increase or decrease in the scope of services furnished by the FQHC/RHC during Fiscal Year 2001. b. Beginning October 1, 2001, and for each fiscal year thereafter, the Department will pay FQHCs/RHCs, on a per visit basis, the amount paid for the preceding fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) applicable to primary care services for the current fiscal year, adjusted to take into account any increase or decrease in the scope of such services furnished by the FQHC/RHC during that fiscal year. c. For FQHCs/RHCs newly qualified after fiscal year 2000, the Department will pay for the initial year, on a per visit basis, 100% of the reasonable costs related to provision of Medicaid-covered services of other centers/clinics located in the same or adjacent areas with similar caseloads. In the absence of such other centers/clinics, the Department will use the FQHC's/RHC's cost report to set the rate. For the next fiscal year, the