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State/Territory Name: MN

State Plan Amendment (SPA) #: 13-026

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

June 11, 2013

James Golden, State Medicaid Director
Minnesota Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

Dear Mr. Golden:

Enclosed for your records is an approved copy of the following State Plan Amendment:

Transmittal #13-026 - Payments to RHCs and FQHCs
--Effective Date: July 1, 2013

If you have any additional questions, please have a member of your staff contact Courtenay Savage at (312) 353-3721 or via e-mail at Courtenay.Savage@cms.hhs.gov.

Sincerely,

/s/
Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Ann Berg, MDHS
Sean Barrett, MDHS

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTER FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 13-26

2. STATE: Minnesota

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTER FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2013

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902(bb) of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY '14 $ 105,500
b. FFY '15 $ 158,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, pages 4 – 5g

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
~~Community Paramedic Services~~ Payments to RHCs & FQHCs
CFR 5/29/14

11. GOVERNOR'S REVIEW *(Check One)*:
x GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

16. RETURN TO:
Sean Barrett
Minnesota Department of Human Services
Federal Relations Unit
PO Box 64983
St. Paul, MN 55164-0983

13. TYPED NAME:
Ann Berg

14. TITLE:
Deputy Medicaid Director

15. DATE SUBMITTED:
September 27, 2013

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 27, 2013

18. DATE APPROVED: June 11, 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2013

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME:
Verlon Johnson

22. TITLE:
Associate Regional Administrator

23. REMARKS:

FORM CMS-179 (07-92)

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic.

A clinic receives payment based on payment methodology in effect on December 31, 2000 until its prospective payment system (PPS) rate(s) is/are determined in accordance with §1902(bb) of the Social Security Act. The Department will reconcile a clinic's payments back to January 1, 2001 when the clinic's PPS rate(s) is/are determined. The PPS and alternative payment methodology (APM I, APM II, and APM III) rates for clinics will include a rate for dental services, if provided, and a rate for all other rural health clinic services of the provider or provider group. Hereinafter, "all other rural health clinic services of the provider or provider group" will be referred to as "medical services."

Prospective Payment System (PPS) Methodology

Rates are computed using a clinic's fiscal year trended forward to December 31, 2000. For the purposes of compliance with §1902(bb)(6) of the Act, the inflation of the rate will occur each year on January 1. January 1 through December 31 will be the "fiscal year." If applicable, the clinic must provide information regarding changes in the scope of services, including the budgeted cost of providing new services and any projected increase or decrease in the number of encounters due to the change. Any adjustment to the clinic's rate for changes in the scope of services will be effective on the first day of the month following the scope of services change. When determination of the revised PPS rate occurs after the revised rate's effective date, retroactive claims adjustments to the revised rate will be made back to the effective date.

In order to comply with §1902(bb) of the Act, the Department utilizes a formula using a clinic's fiscal year 1999 and fiscal year 2000 cost report information trended forward to December 31, 2000. The trended costs for the two fiscal years are combined and divided by the combined encounter information for the two years, resulting in the average cost rate. Encounters include all face-to-face encounters provided by clinic professionals, including all encounters provided by clinic staff outside of the clinic to clinic patients.

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic.

In order to comply with §1902(bb)(4) of the Act, for a clinic that first qualifies as a clinic provider beginning on or after fiscal year 2000, the Department will compare the new clinic to other clinics in the same or adjacent areas with similar case loads. If no comparable provider exists, the Department will compute a clinic-specific rate based upon the clinic's budget or historical costs adjusted for changes in the scope of services.

~~A clinic providing services under a contract with a Medicaid managed care entity (MCE) will receive quarterly state supplemental payments for the cost of providing such services. The supplemental payments are the difference between the payments the clinic receives from the MCE and the payments the clinic would have received in accordance with the PPS methodology of §1902(bb) of the Act.~~

Alternative Payment Methodology I

For a rural health clinic paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, the methodology is 100% of cost as determined using Medicare cost principles, plus: 1)an additional annual payment described below, for state fiscal year 2011 and thereafter which includes a Department medical education payment for each state fiscal year and distributed to a sponsoring institution prior to April 30 of each year for the previous state fiscal year for distribution to Medical Assistance-enrolled teaching clinics, and 2) qualifying payments for meeting the incentive criteria for achieving optimal diabetic or cardiovascular care as described below in item ~~D~~C.

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic. (continued)

The Department will pay for clinic services as follows:

A. A clinic will be paid for the reasonable cost of clinic services and other ambulatory services, less the cost of providing dental services, on the basis of the cost reimbursement principles in 42 CFR Part 413. The Department will pay for medical~~other ambulatory services and clinic~~ services, less the costs of providing dental services, at a single rate per visit based on the cost of all services furnished by the clinic.

B. A clinic will be paid for providing dental services at a rate per visit based on the cost of dental services furnished by the clinic.

C. Effective July 1, 2007, through June 30, 2009, eligible rural health clinics are paid an additional $125 plus 2% every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:
   - Blood pressure less than 140/90; and
   - Lipids less than 100; and
   - Patient is taking aspirin daily if over age 40; and
   - Patient is not using tobacco; and
   - For diabetic only, Hemoglobin A1c levels at less than 8.

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic. (continued)

Each recipient must have had at least two prior office visits with the claiming clinic within the six months before the submission of the claim for the additional payment. Eligible clinics must demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. Clinics must submit documentation of the provision of specific services and complete clinical results per recipient that meet the above criteria for optimal diabetic and/or cardiovascular care. Effective July 1, 2009, the rate adjustment is $250 plus 2% every six months when all of the above criteria are met.

The base rates as described in this item are adjusted by ~~the following~~ paragraph~~(s),~~ cc. of Supplement 2 entitled, Supplemental Payment for Medical Education ~~of Supplement 2~~.~~:~~

~~cc. Supplemental payment for medical education~~

Alternative Payment Methodology II

For a rural health clinic paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, the methodology is the clinic’s PPS rate plus 4 percent through State Fiscal Year 2005.

Effective January 1, 2006, the methodology is the clinic’s PPS rate plus: 1) 2 percent plus 2)an additional annual payment described below, for state fiscal year 2011 and thereafter, which includes a Department medical education payment made for each state fiscal year to a sponsoring institution prior to April 30 of each year for the previous state fiscal year for distribution to Medical Assistance enrolled teaching clinics, 3) beginning July 1, 2007, qualifying payments for meeting incentive criteria for achieving optimal diabetic or cardiovascular care as described below in item ~~B~~A; and 4) beginning July 1, 2010, qualifying payments for health care home services as described in item ~~C~~B.

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic. (continued)

A. Effective July 1, 2007, through June 30, 2009, eligible rural health clinics are paid an additional $125 plus 2% every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:

- Blood pressure less than 140/90; and
- Lipids less than 100; and
- Patient is taking aspirin daily if over age 40; and
- Patient is not using tobacco; and
- For diabetic only, Hemoglobin A1c levels at less than 8.

Each recipient must have had at least two prior office visits with the claiming clinic within the six months before the submission of the claim for the additional payment. Eligible clinics must demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. To qualify for the rate adjustment, the clinic must submit documentation of the provision of specific services and complete clinical results per recipient that meet the above criteria for optimal diabetic and/or cardiovascular care. Effective July 1, 2009, the rate adjustment is $250 plus 2% every six months when all of the above criteria are met.

B. Effective July 1, 2010, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 1-3 major chronic conditions receiving Group 1 health care home services is the lower of:

- Submitted charge; or
- $10.14, plus 2 percent.

Effective July 1, 2010, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 4-6 major chronic conditions receiving Group 2 health care home services, is the lower of:

- Submitted charge; or
- $20.27, plus 2 percent.

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic. (continued)

Effective July 1, 2010, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 7-9 major chronic conditions receiving Group 3 health care home services is the lower of:

- Submitted charge; or
- $40.54, plus 2 percent.

Effective July 1, 2010, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:

- Submitted charge; or
- $60.81, plus 2 percent.

For each of the Groups 1-4 above, the payment rates listed will be increased by 15% if either of the following apply:

- The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their health care; or
- The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.

~~A rural health clinic providing services under a contract with a Medicaid MCE will receive quarterly state supplemental payments for the cost of providing such services. The supplemental payments are an estimate of the difference between the payments the clinic receives from the MCE and the payments the clinic would have received in accordance with the alternative payment methodology of §1902(bb)(6) of the Act.~~

The base rates as described in this item are adjusted by paragraph cc. of Supplement 2 entitled, Supplemental Payment for Medical Education.

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic.

Alternative Payment Methodology III

For a rural health clinic paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, the methodology reimburses the clinic for a single medical visit at either the clinic's PPS rate, APM I rate, or APM II rate as agreed to by the clinic. When the clinic provides services to a patient through both a somatic medical and mental health encounter on the same day, the rate for the visit will be 200% of what would otherwise be paid under the PPS, APM I, or APM II methodologies.

Payment

A clinic providing services under a contract with a Medicaid managed care entity (MCE) will receive monthly state supplemental payments for the cost of providing such services. The supplemental payments are the difference between the payments the clinic receives from the MCE and the payments the clinic would have received in accordance with the PPS or chosen alternative payment methodology (APM I, APM II, or APM III).

At the end of the clinic's fiscal year, the total amount of supplemental and MCE entity payments received will be reviewed against the amount that the actual number of visits provided under the clinic's contract with the MCE would have yielded under the clinic's chosen Medicaid fee-for-service ~~alternative payment~~ methodology (PPS, APM I, APM II, or APM III). The clinic will be paid the difference between the amount calculated using the Medicaid fee-for-service ~~alternative payment~~ methodology and actual number of visits, and the total amount of supplemental and MCE payments received, if the Medicaid fee-for-service ~~alternative~~ amount exceeds the total amount of supplemental and MCE payments. The clinic will refund the difference between the Medicaid fee-for-service ~~alternative~~ amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received, if the Medicaid fee-for-service ~~alternative~~ amount is less than the total amount of supplemental and MCE payments.

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic. (continued)

For rural health clinic payments, “visit” means a face-to-face encounter between a clinic patient and any health professional whose services are paid under the State plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

The State uses the clinic’s audited Independent Rural Health Clinic/Freestanding Federally Qualified Health Center worksheet, Statistical Data, and Certification Statement to establish payment rates. The State makes adjustments for:

A. Medicaid coverage of services that differs from Medicare coverage;

B. the applicable visits; and

C. the establishment of a separate dental payment rate, if dental services are provided.

The State limits like services for Medicare and Medicaid to the respective Medicare limit for the year. Time periods that span more than one calendar year are limited to the respective Medicare limit for each time period.

For purposes of this item, “rural health clinic services” means those services listed in 42 CFR §440.20(b); “ambulatory services” means those services listed in 42 CFR §440.20(c).

~~The base rates as described in this item are adjusted by the following paragraph(s) of Supplement 2:~~

~~cc. Supplemental payment for medical education~~

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC.

A FQHC receives payment based on payment methodology in effect on December 31, 2000 until its prospective payment system (PPS) rate(s) is/are determined in accordance with §1902(bb) of the Social Security Act. The Department will reconcile a FQHC's payments back to January 1, 2001 when the FQHC's PPS rate(s) is/are determined. The PPS and alternative payment methodology (APM I, APM II, and APM III) rates for FQHCs will include a rate for dental services, if provided, and a rate for all other FQHC services of the provider or provider group. Hereinafter, "all other FQHC services of the provider or provider group" will be referred to as "medical services."

Prospective Payment System (PPS) Methodology

Rates are computed using a FQHC's fiscal year trended forward to December 31, 2000. For the purposes of compliance with §1902(bb)(3) of the Act, the inflation of the rate will occur each year on January 1. January 1 through December 31 will be the "fiscal year." If applicable, the FQHC must provide information regarding changes in the scope of services, including the budgeted cost of providing new services and any projected increase or decrease in the number of encounters due to the change. Any adjustment to the FQHC's rate for changes in the scope of services will be effective on the first day of the month following the scope of services change. When determination of the revised PPS rate occurs after the revised rate's effective date, retroactive claims adjustments to the revised rate will be made back to the effective date.

In order to comply with §1902(bb) of the Act, the Department utilizes a formula using a FQHC's fiscal year 1999 and fiscal year 2000 cost report information trended forward to December 31, 2000. The trended costs for the two fiscal years are combined and divided by the combined encounter information for the two years, resulting in the average cost rate. Encounters include all face-to-face encounters provided by FQHC professionals, including all encounters provided by FQHC staff outside of the FQHC to FQHC patients.

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (continued)

In order to comply with §1902(bb)(4) of the Act, for a FQHC that first qualifies as a FQHC providers beginning on or after fiscal year 2000, the Department will compare the new FQHC to other FQHCs in the same or adjacent areas with similar case loads. If no comparable provider exists, the Department will compute a FQHC-specific rate based upon the FQHC's budget or historical costs adjusted for changes in the scope of services.

~~A FQHC providing services under a contract with a Medicaid managed care entity (MCE) will receive quarterly state supplemental payments for the cost of providing such services. The supplemental payments are the difference between the payments the FQHC receives from the MCE and the payments the FQHC would have received in accordance with the PPS methodology of §1902(bb) of the Act.~~

Alternative Payment Methodology I

For a FQHC paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, an interim rate is established, subject to reconciliation at the end of the cost reporting period. The alternative payment methodology is 100% of cost as determined using Medicare cost principles, plus: 1)an additional annual payment described below, for state fiscal year 2011 and thereafter, which includes a Department medical education payment made for each state fiscal year to a sponsoring institution prior to April 30 of each year for the previous state fiscal year for distribution to Medical Assistance enrolled teaching FQHCs, and 2)qualifying payments for meeting incentive criteria for achieving optimal diabetic or cardiovascular care as described below in item ~~D~~C.

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (continued)

The Department will pay for FQHC services as follows:

A. A FQHC will be paid for the reasonable cost of FQHC services and other ambulatory services, less the cost of providing dental services, on the basis of the cost reimbursement principles in 42 CFR Part 413. The Department will pay for medical~~other ambulatory services and FQHC~~ services, less the cost of providing dental services, at a single rate per visit based on the cost of all services furnished by the FQHC.

B. A FQHC will be paid for providing dental services at a rate per visit based on the cost of dental services furnished by the FQHC.

C. Effective July 1, 2007, through June 30, 2009, eligible FQHCs are paid an additional $125 plus 2% every six months for each recipient for whom the FQHC demonstrates optimal diabetic and/or cardiovascular care which includes:
   - Blood pressure less than 140/90; and
   - Lipids less than 100; and
   - Patient is taking aspirin daily if over age 40; and
   - Patient is not using tobacco; and
   - For diabetic only, Hemoglobin A1c levels at less than 8.

2.c. Federally qualified health center (FQHC)services and other ambulatory services that are covered under the plan and furnished by a FQHC (continued).

Each recipient must have had at least two prior office visits with the claiming FQHC within the six months before the submission of the claim for the additional payment. Eligible FQHCs must demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. To qualify for the rate adjustment, the FQHC must submit documentation of the provision of specific services and complete clinical results per recipient that meet the criteria for optimal diabetic and/or cardiovascular care. Effective July 1, 2009, the rate adjustment is $250 plus 2% every six months when all of the above criteria are met.

The base rates as described in this item are adjusted by ~~the following~~ paragraph~~(s),~~ cc. of Supplement 2 entitled, Supplemental Payment for Medical Education ~~of Supplement 2~~.~~:~~

~~cc. Supplemental payment for medical education~~

Alternative Payment Methodology II

For a FQHC paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, the methodology is the FQHC's PPS rate plus 4 percent through State Fiscal Year 2005.

Effective January 1, 2006, the methodology is the FQHC's PPS rate plus: 1) 2 percent plus 2)for state fiscal year 2011 and thereafter, which includes a Department medical education payment made for each state fiscal year to a sponsoring institution prior to April 30 of each year for the previous state fiscal year for distribution to Medical Assistance-enrolled teaching FQHCs, 3)beginning July 1, 2007, qualifying payments for meeting incentive criteria for achieving optimal diabetic or cardiovascular care as described below in item ~~B~~A; and 4) beginning July 1, 2010, qualifying payments for health care home services as described in item ~~C~~B.

2.c. Federally qualified health center (FQHC)services and other ambulatory services that are covered under the plan and furnished by a FQHC (continued).

A. Effective July 1, 2007, through June 30, 2009, eligible rural health clinics are paid an additional $125 plus 2% every six months for each recipient for whom the provider demonstrates optimal diabetic and/or cardiovascular care which includes:

- Blood pressure less than 140/90; and
- Lipids less than 100; and
- Patient is taking aspirin daily if over age 40; and
- Patient is not using tobacco; and
- For diabetic only, Hemoglobin A1c levels at less than 8.

Each recipient must have had at least two prior office visits with the claiming clinic within the six months before the submission of the claim for the additional payment. Eligible clinics must demonstrate the above optimal diabetic and/or provision of specific services and complete clinical results per recipient that meet the criteria for optimal diabetic and/or cardiovascular care. Effective July 1, 2009, the rate adjustment is $250 plus 2% every six months when all of the above criteria are met.

B. Effective July 1, 2010, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 1-3 major chronic conditions receiving Group 1 health care home services is the lower of:

- Submitted charge; or
- $10.14, plus 2 percent.

Effective July 1, 2010, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 4-6 major chronic conditions receiving Group 2 health care home services is the lower of:

- Submitted charge; or
- $20.27, plus 2 percent.

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (continued)

Effective July 1, 2010, for FQHCs certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 7-9 major chronic conditions receiving Group 3 health care home services is the lower of:

- Submitted charge; or
- $40.54, plus 2 percent.

Effective July 1, 2010, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:

- Submitted charge; or
- $60.81, plus 2 percent.

For each of the Groups 1-4 above, the payment rates listed will be increased by 15% if either of the following apply:

- The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their health care; or
- The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.

~~A FQHC providing services under a contract with a Medicaid MCE will receive quarterly state supplemental payments for the cost of providing such services. The supplemental payments are an estimate of the difference between the payments the FQHC receives from the MCE and the payments the FQHC would have received in accordance with the alternative payment methodology of §1902(bb)(6) of the Act.~~

The base rates as described in this item are adjusted by paragraph cc. of Supplement 2 entitled, Supplemental Payment for Medical Education.

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (continued)

Alternative Payment Methodology III

For a FQHC paid under this alternative payment methodology in accordance with §1902(bb)(6) of the Act, the methodology reimburses the FQHC for a single medical visit at either the FQHC's PPS rate, APM I rate, or APM II rate as agreed to by the FQHC. When the FQHC provides services to a patient through both a somatic medical and mental health encounter on the same day, the rate for the visit will be 200% of what would otherwise be paid under the PPS, APM I, or APM II methodologies.

Payment

A FQHC providing services under a contract with a Medicaid managed care entity (MCE) will receive monthly state supplemental payments for the cost of providing such services. The supplemental payments are the difference between the payments the FQHC receives from the MCE and the payments the FQHC would have received in accordance with the PPS or chosen alternative payment methodology (APM I, APM II, or APM III).

At the end of the FQHC's fiscal year, the total amount of supplemental and MCE entity payments received will be reviewed against the amount that the actual number of visits provided under the FQHC's contract with the MCE would have yielded under the FQHC's chosen Medicaid fee-for-service ~~alternative payment~~ methodology (PPS, APM I, APM II, or APM III). The FQHC will be paid the difference between the amount calculated using the Medicaid fee-for-service ~~alternative payment~~ methodology and actual number of visits, and the total amount of supplemental and MCE payments received, if the Medicaid fee-for-service ~~alternative~~ amount exceeds the total amount of supplemental and MCE payments. The FQHC will refund the difference between the Medicaid fee-for-service ~~alternative~~ amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received, if the Medicaid fee-for-service ~~alternative~~ amount is less than the total amount of supplemental and MCE payments.

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (continued)

For FQHC payments, "visit" means a face-to-face encounter between a FQHC patient and any health professional whose services are paid under the State plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

The State uses the FQHC's audited Independent Rural Health Clinic/Freestanding Federally Qualified Health Center worksheet, Statistical Data, and Certification Statement to establish payment rates. The State makes adjustments for:

A. Medicaid coverage of services that differs from Medicare coverage;

B. the applicable visits; and

C. the establishment of a separate dental payment rate, if dental services are provided.

The State limits like services for Medicare and Medicaid to the respective Medicare limit for the year. Time periods that span more than one calendar year are limited to the respective Medicare limit for each time period.

~~The base rates as described in this item are adjusted by the following paragraph(s) of Supplement 2:~~

~~cc. Supplemental payment for medical education~~