METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

2. b. Rural Health Clinic Services/Federally Qualified Health Centers

☒ The payment methodology for FQHCs/RHCs will conform to section 702 of the BIPA 2000 legislation.

☒ The payment methodology for FQHCs/RHCs will conform to the BIPA 2000 requirements Prospective Payment System (PPS).

☒ The payment methodology for FQHCs/RHCs will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology:

1. Is agreed to by the State and the center or clinic; and
2. Results in payment to the center or clinic of an amount which is at least equal to the PPS payment rate.

Alternative Payment Methodologies

In any fiscal year following FY 2002, an FQHC/RHC has the option to retain payment under the standard methodology defined in 1902(bb)(6) or to adopt an APM methodology different from the Medicaid BIPA PPS. To utilize the APM methodology, compliance with specific statutory requirements must be met. Firstly, the State and each individual FQHC/RHC must mutually agree to the APM's application. Additionally, the methodology must ensure that the center or clinic receives a payment at least equivalent to their entitlement under the Medicaid BIPA PPS rate.

1. Alternative Payment Methodology (APM #1 effective 01/01/2018 – 06/30/2023)

Effective January 1, 2018 FQHCs/RHCs electing the APM were paid under either (a) or (b) below for the period of January 1, 2018 through December 31, 2021. Effective January 1, 2022 through June 30, 2023 FQHCs/RHCs electing the APM were paid under (a) below.

a) APM #1 Baseline Rates

Rebasing the BIPA Base rate to the 2016 Medicare Cost Reports.

Included the $5.00 Medicare AIR bump for FQHC providers that were in practice in 2010.

Increased by the Medicare Economic Index (MEI) inflationary factor.

b) Differential APM

i. APM 25% of APM #1 Baseline Rates + 75% of the 2017 APM for dates of service January 1, 2019 through December 31, 2019.

ii. APM 50% of APM #1 Baseline Rates + 50% of the 2017 APM for dates of service January 1, 2020 through December 31, 2020.

iii. APM 75% of APM #1 Baseline Rates + 25% of the 2017 APM for dates of service January 1, 2021 through December 31, 2021.

2. Alternative Payment Methodology (APM #2 effective 07/01/2023 – 02/20/2024)

Effective July 1, 2023 FQHCs/RHCs electing the APM were paid with the following methodology for the period of July 1, 2023 through February 20, 2024:

APM #2 utilizes the FQHC/RHC costs associated with their 2016 Medicare Cost Report and includes the $5.00 Medicare AIR bump for FQHC providers that were in practice during CY 2010. The rate calculated under this Alternative Payment Methodology (APM #2) also includes a 3.8% increase based off CY 2023 MEI plus an additional 10% Legislative directed increase.

3. Alternative Payment Methodology (APM #3 effective 02/21/2024)

Effective February 21, 2024 FQHCs/RHCs electing the APM will be paid with the following methodology:

APM #3 utilizes APM #2 as the base while including a 4.6% increase based off CY 2024 MEI.

~~Effective January 1, 2022, p~~Payment to RHC's and FQHC's not electing the APM will be made at the federal Prospective Payment System (PPS) payment level consistent with BIPA and adjusted for changes in scope and reasonable costs. Rates for FQHCs and RHCs were last updated effective ~~July 1, 2023~~February 21, 2024.

FQHCs and RHCs are free to participate in the Medicaid Next Generation Accountable Care Organization (ACO) Program.

DVHA requests all facilities submit cost reports each year to DVHA by May of each calendar year. In addition, if the facility is requesting a change to its PPS rate based on scope of service or reasonable cost changes, it must include a copy of its most current cost report with the request for a PPS review. These reviews will be conducted throughout the year and PPS rates adjusted, if appropriate, per the results of the review.

As of January 1, 2018, DVHA will no longer conduct cost settlement activities related to FQHC and RHC encounter rate setting. The cost report submissions, therefore, will be used to support the scope of service and reasonable cost process and not for any additional cost settlement activities.