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

reimbursement principles in 42 CFR Part 413. The Department will pay for 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, the additional annual payment increases the Medical Assistance payment in an amount equal to:

(1) $7,575,000 multiplied by a proportion equal to the clinic's public program revenue divided by the total amount of public program revenue of all eligible training sites. Public program revenue is the sum of a provider's revenue from medical assistance, prepaid medical assistance, general assistance medical care and, prepaid general assistance medical care.

(2) For clinics with public program revenue equal to or greater than 0.98 percent of the total public program revenue of all eligible training sites, payments are increased by 20 percent.

(3) Payments to training sites with public program revenue less than 0.98 percent of the total public program revenue of all training eligible sites are reduced proportionately to fund the payment increases described in sub-item (2).

D. 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 ~~130/80~~ 140/90; and
- Lipids less than 100; and

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

- 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. 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.

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)(for Medical Assistance enrolled teaching clinics) an additional annual payment described below, for: a) State Fiscal Year 2006 (July 1, 2005 through June 30, 2006), which includes a Department payment made for that state fiscal year and distributed by a sponsoring institution prior to October 1, 2006; b) State Fiscal Year 2007 (July 1, 2006 through June 30, 2007), which includes a Department payment made for that state fiscal year and distributed by a sponsoring institution prior to October 1, 2007; and c) for state fiscal year 2008 and thereafter, which includes a Department medical education payment made for each state fiscal year and distributed by a sponsoring institution prior to October 1 of each year for the previous state fiscal year, ~~and~~ 3) beginning July 1, 2007, qualifying payments for meeting incentive criteria for achieving optimal diabetic or cardiovascular care as described below in item B; and 4) beginning July 1, 2010, qualifying payments for health care home services as described in item 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)

A. Effective July 1, 2007, the additional annual payment increases the Medical Assistance payment in an amount equal to:

(4) $7,575,000 multiplied by a proportion equal to the clinic's public program revenue divided by the total amount of public program revenue of all eligible training sites. Public program revenue is the sum of a provider's revenue from medical assistance, prepaid medical assistance, general assistance medical care and, prepaid general assistance medical care.

(5) For clinics with public program revenue equal to or greater than 0.98 percent of the total public program revenue of all eligible training sites, payments are increased by 20 percent.

(6) Payments to training sites with public program revenue less than 0.98 percent of the total public program revenue of all training eligible sites are reduced proportionately to fund the payment increases described in sub-item (2).

(7) Clinics with no public program revenue are not eligible for increased payments.

B. 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~~ 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 ~~7~~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

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

reimbursement principles in 42 CFR Part 413. The Department will pay for 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, the additional annual payment increases the Medical Assistance payment by an amount equal to:

(1) $7,575,000 multiplied by a proportion equal to the clinic's public program revenue divided by the total amount of public program revenue of all eligible training sites. Public program revenue is the sum of a provider's revenue from medical assistance, prepaid medical assistance, general assistance medical care and, prepaid general assistance medical care.

(2) For clinics with public program revenue equal to or greater than 0.98 percent of the total public program revenue of all eligible training sites, payments are increased by 20 percent.

(3) Payments to training sites with public program revenue less than 0.98 percent of the total public program revenue of all training eligible sites are reduced proportionately to fund the payment increases described in sub-item (2).

D. 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 ~~130/80~~ 140/90; and
- Lipids less than 100; and
- Patient is taking aspirin daily if over age 40; and

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

- 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 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.

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 Medical Assistance enrolled teaching FQHCS) an additional annual payment described below, for: a) State Fiscal Year 2006 (July 1, 2005 through June 30, 2006), which includes a Department payment made for that state fiscal year and distributed by a sponsoring institution prior to October 1, 2006; b) State Fiscal Year 2007 (July 1, 2006 through June 30, 2007), which includes a Department payment made for that state fiscal year and distributed by a sponsoring institution prior to October 1, 2007; and c) for state fiscal year 2008 and thereafter, which includes a Department medical education payment made for each state fiscal year and distributed by a sponsoring institution prior to October 1 of each year for the previous state fiscal year, 3)beginning July 1, 2007, qualifying payments for meeting incentive criteria for achieving optimal diabetic or cardiovascular care as described below in item B; and 4) beginning July 1, 2010, qualifying payments for health care home services as described in item 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).

A. Effective July 1, 2007, the additional annual payment increases the Medical Assistance payment in an amount equal to:

(8) $7,575,000 multiplied by a proportion equal to the clinic's public program revenue divided by the total amount of public program revenue of all eligible training sites. Public program revenue is the sum of a provider's revenue from medical assistance, prepaid medical assistance, general assistance medical care and, prepaid general assistance medical care.

(9) For clinics with public program revenue equal to or greater than 0.98 percent of the total public program revenue of all eligible training sites, payments are increased by 20 percent.

(10) Payments to training sites with public program revenue less than 0.98 percent of the total public program revenue of all training eligible sites are reduced proportionately to fund the payment increases described in sub-item (2).

(11) Clinics with no public program revenue are not eligible for increased payments.

B. 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 ~~130/80~~ 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 ~~7~~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

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere

Effective for services provided on or after January 1, 2011, payment for physician services is the lowest of:

(1) submitted charges; or
(2) (a) the Resource Based Relative Value Scale calculated values (as published by the Centers for Medicare & Medicaid Services November 2010); or
(b) State agency established rate; or
(c) For delivery services, including cesarean delivery services that are not complicated:
59400, 59510, 59610:$1387.89
59409, 59514, 59612 $540.00
59410, 59515, 59614 $696.73

The Resource Based Relative Value Scale conversion factors are:
Evaluation and Management services: $27.10
Obstetric services: $27.10
Psychiatric services: $31.56
All other physician services: $24.52

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

- Blood pressure less than ~~130/80~~ 140/90; and
- Lipids less than 100; and
- Patient is taking aspirin 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 provider within the six months before the submission of the claim for the additional payment. Eligible providers are physicians who demonstrate the above optimal diabetic and/or cardiovascular care for each recipient. To qualify for the rate adjustment, providers 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 every six months when all of the above criteria are met.