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State/Territory Name: MN

State Plan Amendment (SPA) #: 16-0011

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

May 11, 2017

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

Dear Ms. Zimmerman:

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

Transmittal #16-0011 --Revising the state plan to provide reimbursement to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for behavioral health home services. Amendment also makes a technical revision to Alternative Payment Method I to reimburse behavioral health home services.

--Effective Date: July 1, 2016

--Approval Date: May 9, 2017

If you have any additional questions, please have a member of your staff contact Sandra Porter at (312) 353-8310 or via e-mail at Sandra.Porter@cms.hhs.gov.

Sincerely,

/s/
Alan Freund
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosures

cc: Ann Berg, MDHS
Sean Barrett, MDHS

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: 16-11	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, 2016	

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 (in thousands): a. FFY '17 $0 b. FFY '18 $0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, pages 4 – 4e and 5 – 5e	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same

10. SUBJECT OF AMENDMENT:
Payment to Federally Qualified Health Centers and Rural Health Clinics

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 29, 2016	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 29, 2016	18. DATE APPROVED: May 9, 2017
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2016	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Alan Freund	22. TITLE: Acting 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.

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.

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 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 C~~.~~; 3) effective for services provided on or after July 1, 2010, qualifying payments for health care home services as described in item D; and 4) effective for services provided on or after July 1, 2016, qualifying payments for behavioral health home services as described in item E.

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 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 for services provided on or after July 1, 2009, the rate adjustment is $250 plus 2% every six months when all of the above criteria are met.

D. Effective for services provided on or after 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 for services provided on or after 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.

Effective for services provided on or after 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 for services provided on or after 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.

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 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.

E. Effective for services provided on or after July 1, 2016, for clinics certified as meeting the behavioral health home qualifications, and payment criteria, described in Attachment 3.1-H, payment for BHH services is $245.00 per member, per month. During the recipient's first six months of participation, the behavioral health home will receive an enhanced payment rate of $350.00 per member, per month.

The base rates as described in this item are adjusted by paragraph cc. of Supplement 2 entitled, 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 for services provided on or after 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) effective for services provided on or after ~~beginning~~ July 1, 2007, qualifying payments for meeting incentive criteria for achieving optimal diabetic or cardiovascular care as described below in item A; ~~and~~ 4) effective for services provided on or after ~~beginning~~ July 1, 2010, qualifying payments for health care home services as described in item B~~.~~; 5) effective for services provided on or after July 1, 2016, qualifying payments for behavioral health 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, 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 for services provided on or after July 1, 2009, the rate adjustment is $250 plus 2% every six months when all of the above criteria are met.

B. Effective for services provided on or after 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 for services provided on or after 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 for services provided on or after 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 for services provided on or after 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.

C. Effective for services provided on or after July 1, 2016, for clinics certified as meeting the behavioral health home qualifications, and payment criteria, described in Attachment 3.1-H, payment for BHH services is $245.00 per member, per month. During the recipient's first six months of participation, the behavioral health home will receive an enhanced payment rate of $350.00 per member, per month.

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.

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.

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.

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 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 the incentive criteria for achieving optimal diabetic or cardiovascular care as described below in item C~~.~~; 3) effective for services provided on or after July 1, 2010, qualifying payments for health care home services as described in item D; and 4) effective for services provided on or after July 1, 2016, qualifying payments for behavioral health home services as described in item E.

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 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 for services provided on or after July 1, 2009, the rate adjustment is $250 plus 2% every six months when all of the above criteria are met.

D. Effective for services provided on or after 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 for services provided on or after 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.

   Effective for services provided on or after 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 for services provided on or after 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 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.

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 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.

E. Effective for services provided on or after July 1, 2016, for FQHCs certified as meeting the behavioral health home qualifications, and payment criteria, described in Attachment 3.1-H, payment for BHH services is $245.00 per member, per month. During the recipient's first six months of participation, the behavioral health home will receive an enhanced payment rate of $350.00 per member, per month.

The base rates as described in this item are adjusted by paragraph cc. of Supplement 2 entitled, 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 for services provided on or after 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) effective for services provided on or after ~~beginning~~ July 1, 2007, qualifying payments for meeting incentive criteria for achieving optimal diabetic or cardiovascular care as described below in item A; and 4) effective for services provided on or after ~~beginning~~ July 1, 2010, qualifying payments for health care home services as described in item B~~.~~; 5) effective for services provided on or after July 1, 2016, qualifying payments for behavioral health 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, 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 for services provided on or after July 1, 2009, the rate adjustment is $250 plus 2% every six months when all of the above criteria are met.

B. Effective for services provided on or after 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 for services provided on or after 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 for services provided on or after 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 for services provided on or after 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 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.

C. Effective for services provided on or after July 1, 2016, for clinics certified as meeting the behavioral health home qualifications, and payment criteria, described in Attachment 3.1-H, payment for BHH services is $245.00 per member, per month. During the recipient's first six months of participation, the behavioral health home will receive an enhanced payment rate of $350.00 per member, per month.

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