STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

LIMITATIONS OF SERVICES (Continued)

b. Rural Health Clinic Services

Rural Health Clinic Services (RHC) services are defined in subparagraphs (B) and (C) of section 1905(a)(2). Reimbursement is limited to the Division's Medicaid-covered services according to a client's Oregon Health Plan (OHP) benefit package. These services include ambulatory services included in the State Plan under Title XIX or Title XXI of the Social Security Act. These services include but are not limited to services provided by physicians, physician assistants, nurse practitioners, nurse midwives, clinical psychologists, clinical social workers, and nurses.

c. Federally Qualified Health Center (FQHC) Services

FQHC services are defined in subparagraphs (B) and (C) of section 1905(a)(2). Reimbursement is limited to the Division's Medicaid-covered services according to a client's Oregon Health Plan (OHP) benefit package. These services include ambulatory services included in the State Plan under Title XIX or Title XXI of the Social Security Act. These services include but are not limited to services provided by physicians, physician assistants, nurse practitioners, nurse midwives, clinical psychologists, clinical social workers, and nurses.

3. Clinical laboratory and pathology services and procedures*

*performed by any provider are reimbursable only after the provider is certified by HCFA as meeting the requirements of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and HCFA has notified OMAP of the assignment of a ten-digit CLIA number. Enforcement of compliance with CLIA requirements will occur only after notification in writing from HCFA.
*are provided subject to the rules and procedures set forth in the Medical-Surgical Services Administrative Rules and Billing Instructions for Oregon Medical Assistance Programs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: OREGON
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

FQHC & RHC Alternate Payment Methodology

Payments to FQHCs & RHC will be determined using an alternative payment methodology (APM) as authorized in Section 1902(bb)(6) of the SSA. The APM will be effective on or after the date the clinic has signed an agreement with the Division. Those FQHCs & RHCs that do not choose the APM will continue to be paid under the Prospective Payment System (PPS) methods.

The APM will convert the clinic's current PPS rate into an equivalent Per Member Per Month (PMPM) rate using historical patient utilization and the medical only cost base rate for the specific clinic. The base rate is determined as illustrated:

- If a clinic PPS rate = $100/medical encounter ;
- The clinic served 5000 Medicaid patients at an average of 3.0 encounters/patient, for total Medicaid medical visit revenue of $1,500,000 (excluding dental and mental health revenue).
- APM rate is based on $ 1,500,000 / 5000 = $300 per patient, per year.
- The clinic's PMPM: $300/12 = $25 PMPM.

The conversion of the clinic's PPS rate to a PMPM includes estimates of the number of Fee-For-Service beneficiaries that will be served by the clinic as well as the average number of encounters/visits that will be delivered.

The APM will be adjusted annually by the MEI as published in the Federal Register.

The interim PMPM rate is not actuarially certified as it pertains to the FFS population and may not result in final payment to the center.

On a quarterly basis, these estimates will be reconciled to actual utilization data in order to monitor whether the payments will be in accordance with section 1902(bb) of the Social" Security Act. To ensure that the appropriate amounts are being paid to each center, the State will perform an annual reconciliation and verify that the enhancement payments made in the previous year were in compliance with Section 1902(bb)(5)(A).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: OREGON
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

FQHC & RHC Alternate Payment Methodology

Utilization data will be pulled two quarters after the end of the year and analysis performed to determine the aggregate difference between the interim PMPM and the PPS for all FQHC & RHC services rendered within the clinic. Any enhanced payments needing to be made to bring total payments to a sum no less than the sum that would have been paid on PPS will be remitted within 120 days of the end of the year.

An adjustment will be made to a center's encounter rate if the center can show that they have experienced a valid change in scope of service. A change in scope of service is defined as a change in the type, intensity, duration and/or amount of services. As outlined in OAR 410-147-0362 a change in the scope of service will occur if: (1) the center adds, drops or expands any service that meets the definition of FQHC & RHC service as defined in section 1905(a)(2)(C) of the Social Security Act; and, (2) the service is included as a covered Medicaid service as defined in the State Plan Amendment.

For clients enrolled with a managed care contractor, the State will pay the center a supplemental payment in addition to the amount paid by the managed care contractor. The supplemental payments, paid in amounts necessary to ensure compliance with Section 1902(bb)(5)(A) of the SSA. The State will pay the enhancements monthly on a per-member-per-month basis.