MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 12-52

Distribution: Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC)

Issued: November 1, 2012

Subject: Prospective Payment per Visit Rate Setting Methodology

Effective: December 1, 2012

Programs Affected: Medicaid, Maternity Outpatient Medical Services (MOMS), MIChild

An FQHC or RHC is reconciled to the prospective payment per visit rate determined under the Prospective Payment System (PPS) or an alternate Memorandum of Agreement. Under the Benefits Improvement and Protection Act of 2000, the PPS per visit payment is equal to 100 percent of the average of the clinics' reasonable costs of providing Medicaid services during Fiscal Years (FY) 1999 and 2000. This bulletin provides clarification of the methodology currently used to determine the prospective payment rate (PPR) for newly established clinics and for clinics approved for rebasing when a scope of service change occurs.

New Facility Prospective Payment per Visit Rate Setting Methodology:

Upon enrollment, an interim PPR will be established for new clinics equal to the facility type average rate for the county in which they are located or the statewide average (if no previous average exists for the county subject to any limit applied to the specific facility type). The clinic will be cost settled at the end of its first FY of operation.

After the facility has been in operation for two full cost reporting periods, the average rate per visit for those two periods will be considered the revised PPR for the facility, subject to the following criteria:

- The first year will be inflated to the second fiscal year end using the appropriate Medicare Economic Index (MEI) factors.
- For FQHCs, the PPR shall not exceed the Medicare limit (rural or urban depending upon classification) plus the Medicaid add-on amounts adjusted for MEI.
- For independent RHCs, the rebased PPR shall not exceed the Medicare limit.
- For provider based RHCs, (associated with a hospital with fewer than 50 enrolled beds) the PPR shall not exceed the statewide average cost per visit. The limit will increase annually at a minimum of the MEI factor.
- For provider based RHCs, (associated with a hospital with 50 or more beds) the PPR shall not exceed the Medicare limit.

Scope of Service Change Rebase Request:

Any facility approved for rebasing due to a change in scope of services shall be treated as a new facility. In order to qualify for a scope of service change, the cost related to the specific change must account for an increase or decrease to the existing PPR of five percent or greater. A facility that changes classification to a system utilizing a different rate limit or methodology shall be considered a change of scope (by default).

- Example: an independent rural health clinic that changes ownership to a provider based clinic when the hospital has less than 50 beds is considered to have a change of scope.

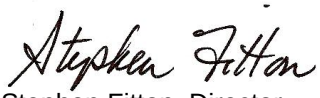
Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved



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