Attachment B – RAPPS Preprint Question 8

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

A minimum of 30 Medicaid managed care encounters in the prior State Fiscal Year (SFY) is required for program eligibility for all payment Components.

Component 1 will be a uniform dollar increase by class. Freestanding and hospital-based rural health clinics will receive a uniform dollar increase for All-Inclusive Clinic Visit, T1015, and office visit codes. Payments will be based on units using each provider's utilization during service period March 1, 2019 to February 2020 with a 7% increase for estimated enrollment growth among the three Medicaid managed care programs (STAR, STAR+PLUS, and STAR Kids). The payments will be paid prospectively on a monthly basis (equal to 1/12 of the annual amount).

Component 2 will be a uniform percentage increase. Freestanding and hospital-based rural health clinics will receive a uniform percentage increase for All-Inclusive Clinic Visit, T1015, and office visit MCO payments, for the STAR/STAR+PLUS/STAR Kids programs. For Component 2, the uniform percent increase will be 3.77% for all rural health clinics and will have a quality component to the payment. Component 1 consists of structure measures. Components 2 consists of process quality measures. Providers are required to report baselines for all process measures as a condition for participation in the program. A separate reconciliation will be performed for rural health clinics based on actual utilization.