

***Federally Qualified Health Center (FQHC)
Medicaid Reimbursement Rate Option***

New York State's Medicaid Program implemented the Ambulatory Patient Group (APG) reimbursement methodology effective December 1, 2008, for hospital outpatient departments and ambulatory surgery services and effective January 1, 2009 for hospital emergency departments. Implementation of the APG reimbursement methodology in Diagnostic and Treatment Centers (DTCs) was approved with a September 1, 2009 implementation date.

FQHCs may participate in the APG reimbursement methodology as an "alternative rate setting methodology" as authorized by Public Health Law Section 2807(8)(f). If a facility is currently being reimbursed using their Prospective Payment System (PPS) rate and would like to participate in the APG reimbursement methodology, complete, sign and email to the Department of Health (Department), at dctffsunit@health.ny.gov, the FQHC Medicaid Reimbursement Option Declaration Form. This signed form must be received by the Department no later than November 1st of the year prior to January 1 of the calendar year the FQHC wishes to participate in APGs.

FQHCs that choose APG reimbursement will remain under this rate methodology until such time as they notify the Department in writing that they no longer wish to participate in APG reimbursement and want to be placed back on the PPS reimbursement method. Such notification must be received by the Department no later than November 1st of the year prior to January 1 of the calendar year the FQHC wishes to have their PPS rate reinstated. Requests should be emailed to the same address as stated above.

Please be advised that FQHCs that do not choose APG reimbursement will be forgoing the opportunity to bill for certain primary care enhancements that are built into APG rates for specific purposes, such as diabetes, asthma education and expanded hours access. Under the Federal and State law, the PPS rate is an all-inclusive cost-based threshold visit rate based on the average of each facility's 1999 and 2000 reported base year costs, trended forward annually using the Medicare Economic Index.

As a "hold harmless" provision, FQHCs that choose APG reimbursement will be eligible to receive a supplemental payment reflecting the difference between total APG reimbursement and the aggregate amount that would have otherwise been paid under the PPS rate, if the latter is greater. Supplemental payments will be calculated on a calendar year and location specific basis using date of service data available to the Department. Payments will be made on a lump-sum basis.



**Department
of Health**

**Office of
Health Insurance
Programs**

**Federally Qualified Health Center (FQHC)
Medicaid Reimbursement Rate Option Declaration Form
Ambulatory Payment Methodology Election**

FQHC Name:

Operating Certificate #:

The undersigned hereby requests that the above-named provider be reimbursed according to the Ambulatory Patient Group (APG) Rate methodology for Medicaid reimbursement.

This request is to be effective January 1, _____. (Please note the effective year.)

Signed form to be emailed by November 1st prior to the January 1st implementation date.

Authorization of Chief Executive Officer or Chief Operating Officer:

Print Name

Title

Signature

Date

Please email the signed declaration form to the following: dtcffsunit@health.ny.gov

Subject of email: FQHC Rate Option Form



**Federally Qualified Health Center (FQHC)
Medicaid Reimbursement Rate Option Declaration Form
Reinstatement of Prospective Payment System (PPS) / FQHC Rate**

FQHC Name:

Operating Certificate #:

The undersigned is requesting that the above-named provider to be reinstated to using its PPS/FQHC rate for Medicaid reimbursement.

This request is to be effective January 1, _____. (Please note the effective year.)

Signed form to be emailed by November 1st prior to the January 1st implementation date.

Authorization of Chief Executive Officer or Chief Operating Officer:

Print Name

Title

Signature

Date

Please email the signed declaration form to the following: dtcffsunit@health.ny.gov

Subject of email: FQHC Rate Option Form